STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, interview, observation, and record review, the facility neglected to provide a safe environment and adequate supervision to protect residents from elopement, when they failed to monitor a known elopement risk for Resident (R)1, failed to update the comprehensive care plan with targeted intervention;, failed to provide adequate supervision when the resident's Wander Guard system was inactive; failed to conduct monthly elopement drills per facility policy; failed to verify door locks per protocols; and failed to develop and implement a performance improvement plan following an actual elopement on 05/13/26. The facility's neglect to provide these services resulted in 1 of 5 sampled residents (R1), who exhibited known wandering behaviors, eloping from the facility unsupervised on 05/22/26. Findings include:ˆ Review of the Summary Statement of Deficiencies, for a Complaint Survey on 05/13/26, indicated the facility was cited at Immediate Jeopardy-F689 when a resident eloped from the facility.ˆ Review of the facility's undated policy titled, Abuse/Neglect Policy & Procedure revealed, Policy. It is the policy of this facility that Abuse/Neglect . will not be tolerated. This includes residents, employees, . Procedure . c) appropriate and sufficient supervision to ensure that staff are able and are meeting the needs of residents with behavior problems, and those who need special care in areas of assistance in ADL's, etc.; d) ensure that the assessment care planning and monitoring of all resident care, especially those with specific behavior problems, is current and appropriate and is being utilized. Procedures were identified as screening, training, prevention, identification, investigation, protection, and reporting responses, but did not include a definition of neglect. Review of the facility's undated policy titled, Exit Seeking/Elopement Policy and Procedure identified, Definition of Elopement: Any resident who has left the building UNWITNESSED and is found to be past the RNC [Ridgeland Nursing Center] parameters. Parameters include: a. past the flower bed of the front door to the oak trees of hospital yard. b. past the fences at each end of the building to property line. c. past the dumpsters at the back of the building to the church yard. Review of the police report from the Ridgeland Police Department dated 05/22/2026 at 5:59:03 revealed, Incident. Incident Nature: Suspicious Person. Occurred From: 05/22/2026 05:58:44. Occurred To: 05/22/2026 05:59:08 . Contact: . Supplemental Narrative 06/02/2026 14:41:38. On May 22, 2026, at approximately 0559 hours, [NAME] County Communications received a call from a school cafeteria employee reporting an unknown adult female on school property attempting to gain entry into the building prior to student arrival. The caller advised the female, described as a Black female wearing pink pajama pants and a gray/black tank top, was observed hiding in bushes near the school, pulling on exterior doors, looking through windows, and attempting to enter through the kitchen and main entrance doors. The caller stated the female did not appear to be a student and appeared to be older in age. Throughout the incident, the caller provided real-time updates on the female's movements around the campus. The female was observed entering and exiting through a front door area, walking around the building, checking windows, and repeatedly pulling on locked doors. Officers responded and made contact with the female. Based on the officer's observations, EMS was requested for an altered mental status evaluation at approximately 0616 hours. Further investigation revealed the female was (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified as [R1], a resident of a local nursing facility. Contact was made with the nursing home, and staff initially believed [R1] was in her room. After being advised she was located at the school, nursing home staff responded to meet with officers. The incident was resolved without reported injuries or criminal activity. EMS evaluated the subject, and appropriate arrangements were made with nursing home staff .Review of a document titled Ad Hoc Quality Assurance & Performance Improvement Meeting, dated 5/22/2026 revealed, . the third column titled Analysis . indicated, Based upon root cause analysis to include staff interviews and observation of the front lobby door, the resident was able to exit out the front lobby door without staff knowledge. r/t (related to) the below: Malfunction of the front lobby door. Resident not placed on 1:1 (one-to-one) supervision when Wander Guard malfunctioned. Q (every) 15 min (minute) checks. Wander guard door not receiving power from fire panel . Review of Certified Nursing Assistant (CNA)GG's statement dated 05/22/26, revealed, I witness [R1] in her room sleep when I started my rounds at 4 am. When I went to change my last resident, [R1] was still in her room at 5:50a. When I walked out the residents [sic] room to continue charting, the town called stating [R1] was across the street at Polaris with an officer (6:15 am). Resident was returned safely to the facility by CNA and officer. Review of CNAEE's statement dated 05/22/26 revealed, I [CNAGG] got check [sic] on [R1] at 5:00am before I started my round, she was in her room safe and sound. [sic] I continue giving patient care to my other residents as I was walking out the room to give care to my next resident my coworker then told me to go and get the nurse because the police was on the phone because [R1] was across the street at the school. [sic] Review of CNAKK's statement dated 05/22/26 revealed, I was in the middle of walking the premises when my coworker informed me of one of the residents escaped. [sic] I immediately tried to help any way I could, but my coworkers had it under control at that point in time. I returned to document my patrol. CNAKK said he had been performing fire watch duties. Review of the untitled document outlining R1's 15-minute checks revealed that the 15-minute checks began on 05/21/26 at 2:30 PM and continued every 15 minutes throughout the night and the morning of 05/22/26. Specifically, Licensed Practical Nurse (LPN)AA documented on 05/22/26 at 5:30 AM, and 5:45 AM, that R1 was sleeping in bed. The document indicated at 0600, Check on pt (patient) .before starting wound care. The document indicated, *Pt (patient) Eloped!!! for the times of 6:15 AM through 6:45 AM. LPNAA documented Vitals check at 7:00 AM. According to the police report, R1 could not have been at the facility at 6:00 AM. Review of R1's admission records revealed she was admitted on [DATE], with diagnoses including but not limited to, intracerebral hemorrhage, dementia, mild protein calorie malnutrition, adjustment disorder with mixed anxiety and mood disorder. Review of R1's Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 05/12/26, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating the resident was unable to complete the interview. Review of R1's record revealed a referral dated 05/11/26 from the hospital for long-term care placement due to increased confusion with orientation to self only, noting she was confused and restless at baseline. R1's progress notes were reviewed and indicated the following: On 05/18/26 at 2:44 PM, Residents (sic) wandering around all day long was able to re-direct for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. On 05/19/2026 at 1:35 PM, She continues to wander but can be redirected for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. On 05/19/26 at 3:03 PM, Residents (sic) wandering around unit all day long was able to re-direct for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. On 05/21/26 at 2:30 PM, Wander Guard to L (left) ankle monitor/check placement Q shift inactive .15-minute monitoring initiated. On 05/22/26 at 1:44 AM, Wander Guard check, inactive 15-minute monitoring initiated. On 05/22/26 at 7:00 AM, placed on 1:1 for exiting the center without staff knowledge. Review of R1's Care Plan revealed a focus area, ELOPMENT: The resident is an elopement risk/wanderer r/t (related to) Disoriented to place, Impaired safety awareness, Resident wander aimlessly, with an initiation date of 05/12/26. Interventions included assess for fall risk, distract resident from wandering by (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering, monitor for fatigue and weight loss, provide structured activities, and Wander Guard to left leg. There was no update to the care plan when 15-minute checks were implemented on 05/21/26 following identification the Wander Guard was not working, as indicated in the progress notes. Review of R1's Elopement Risk Evaluations dated 05/13/26 and 05/22/26, revealed scores of 8 and 14, respectively, indicating high risk for elopement. Review of R1's Physician Orders revealed an order for Wander Guard placement to the left ankle 05/13/26 with checks to be documented on each shift. Review of the R1's record did not identify routine Wander Guard checks every shift. Review of R1's Care Plan revealed a focus area, The resident has impaired cognitive function and impaired thought processes r/t Dementia, Impaired decision-making, Short-term memory loss, with an initiation date of 05/12/26. Interventions included medication and monitoring for side effects and effectiveness, communicate regarding resident capabilities and needs, communication, cues and reorientation, and a consistent routine. During an interview and observation with the Administrator on 06/02/26 at 10:00 AM, he stated, Yes, she got out and went next door to the school resource officer. An observation from the front door to the school parking lot revealed a count of approximately 100-120 steps, depending on the specific place/door of the school building and approximately 115-130 steps to the highway where a 55 mile-per-hour sign was posted. During an interview and observation with the Administrator on 06/02/26 at 11:00 AM, revealed the facility has been having issues with the fire alarm panel since November 2025, and they have been utilizing fire watch to ensure safety until the entire system can be replaced. He said that fire watch consisted of an assigned staff walking around building and monitoring for signs of fire 24 hours per day and 7 days per week. This is and will be ongoing until the state removes it. He said pull tabs are, hit and miss when they work. When asked if he knew this issue had the potential to impact the Wander Guard system, he said, No. I thought it was a completely separate system. And I know it is now. He said the Wander Guard devices are checked for each resident every shift, and the Wander Guard system is checked at the doors daily, every 24 hours. He said the doors had been checked and were all working at 6:00 PM on 05/21/26. He said when the Wander Guard device was checked on 05/21/26 and noted to not be working, the resident was placed on 15-minute checks. When asked if the Wander Guard system should be checked more frequently, he said, No. The daily door checks are placed on a log, and the individual residents' devices are checked each shift. Review of the Ridgeland Nursing Center Exit Door Daily Log indicated, If the doors are not locked at anytime (sic) ACTION needs to be taken immediately and report to the Administrator. The log identified eight exit doors throughout the facility to be checked, including the Front Exit Door. There were columns that were to be completed for each door: Date; Time Checked; Locked (to be marked if true); Not Locked (to be marked if true); Name Print; and Signature. On the document dated 05/21/26, there were check marks for all doors except the Front Exit Door at 10:00 AM. The front door was not check-marked. The other doors check-marked by the Administrator failed to identify whether the door was locked or unlocked and did not print or sign their name in the corresponding columns, rather the Administrator and the DON initialed/signed below the check marks. Review of the facility's Center Stabilization Plan Last updated 05/18/2026, revealed Center: Ridgeland Nursing and Rehabilitation Center, LLC. Last Annual Survey: May 2025. The body of the document revealed, Weekly ADHOC Mtg (meeting) on Tuesdays Full QAPI Review 03/31/2026, 04/28/2026, 05/12/2026, with columns labeled, Item/Goal. Action. Person. Target Date. Follow Up. Comment. There are headings for each topic as follows: Operations and Clinical. Administration. Business Office. Admissions. Clinical. Medical Records. MDS. Pharmacy. Therapy. Grievances. HR. Education. Social Services / Activities. Physical Plant - Maintenance. Housekeeping / Laundry. Dining Services. The facility's QAPI Program was reviewed and identified there was no performance improvement initiative developed and implemented following the complaint survey on 05/13/26 to ensure correction and monitoring to prevent future noncompliance with elopement at the facility. During an interview with R1's family on 06/02/26 at 2:29 PM, revealed she is a nurse, and she stated, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility has no safety protocols. They recently updated and added locks, but they don't have people at the front (entrance) and are short-staffed. She said, No one is at the main entrance, the front, any random person can enter. She offered that she did not agree with the resident being transferred to a different facility, stating, they don't want the liability, and citing that R1's mother had lived at the facility and had dementia as well. She requested to speak with the DON. During an interview CNAGG on 06/02/26 at 3:37 PM, she said she was on duty the night of 05/21/26 through the morning of 05/22/26, during the 11 PM to 7 AM shift along with CNAEE and LPNAA, stating, [CNAEE] was assigned to [R1]. She said she was not assigned to R1 during the shift, but that she checked on R1 at 5:50 AM on behalf of CNAEE. CNAGG stated that she answered the phone at approximately 6:00 AM discovered that R1 was with the officer at the school next to the facility. CNAGG informed the nurse immediately who was providing wound care to another resident. CNAGG said R1 had been on 15-minute checks because the Wander Guard was not working. R1 had been asleep the entire night and had not exhibited any signs of wandering or elopement. CNAGG was then sent over to retrieve R1 from the officer which took a little while. When she and R1 returned, R1 was immediately placed on one-to-one supervision. During an interview with CNAEE on 06/02/26 at 4:35 PM, revealed she was on duty and assigned to R1 on the night of 05/21/26 through the morning of 05/22/26, during the 11 PM to 7 AM shift. She said she documented 15-minute checks throughout the night because R1's Wander Guard was not working. She said she had begun her 5 AM rounds, and I documented she was in bed at 5:50 AM. During an interview with LPNAA on 06/03/26 at 7:55 AM, revealed CNAEE had been assigned to R1's care throughout the night and that she and CNAGG alternated checking on R1 throughout the night as well. Just before LPNAA completed her check, CNAGG had completed a check of the resident. LPNAA performed a check of the resident just before 6:00 AM on 05/22/26. During both checks, the resident was noted to be in bed and asleep. LPNAA then went to another resident's room to provide wound care. CNAEE then entered the room of the resident for whom LPNAA was providing wound care, and notified R1 had been found at the school. LPNAA stated she had no responsibility to complete door alarm checks but that Wander Guard checks are performed each shift. She had learned from the nurse on the previous shift that R1's Wander Guard was not working, and that was the reason she was on 15-minute checks. She did not know why the Wander Guard was not working, but it was still not working at the beginning of her shift. During an interview with the Administrator on 06/02/26 at 6:14 PM, revealed that one would know individual Wander Guard devices were not working if a red light was not found to be flashing when checked. He said that the doors are checked with a test Wander Guard device daily, starting on 05/10/26. The failure of the door alarm system as related to the Wander Guard device was discovered when the technician came to inspect the system on 05/22/26. It was not currently in a policy, but was in the Quality Assurance (QA) tool put into place recently and had been trained on. He said there were no parameters identified on an elopement risk assessment to indicate which interventions to place according to the score of the assessment, that each intervention was determined by the IDT. When asked about resident supervision and there being two incidents of elopement in a 12-day period, the Administrator said, They were two totally separate issues. The initial plan included assessing residents for elopement risk and then implement a plan to prevent elopements based upon their assessment outcomes which was completed for both residents. [R1] had already been identified as an elopement risk. Her elopement occurred as the result of a mechanical failure. She had interventions in place already to include the Wander Guard and 15-minute checks. In all assessments, the IDT provides interventions that are least restrictive to the most restrictive. If warranted by the resident medical condition under the direction of the physician, and in this situation, we did that. The team met, determined the least restrictive safety prevention measure of the resident to include one-to-one as the final measure. I was not aware that the fire alarm was causing issues or lack of power to the Wander Guard system on the doors. As we tested them prior to [R1's elopement on 05/22/26], they were working appropriately as evidenced by me personally checking them daily, and (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they are on the logs between 05/10/26 through 05/21/26. If the facility had been aware this was an issue, a guard would have been placed at the door to ensure the safety of the residents as was placed when facility became aware. There was no record or log provided by the facility to indicate specific testing of the Wander Guard system daily. Review of the Ridgeland Nursing Center Exit Door Daily Log identified areas for staff to document whether eight exit doors were locked or unlocked. There was no area on the log directing staff to test and evaluate Wander Guard functionality, nor was there a column for this to be documented. During an interview with the school resource officer on 06/03/26 at 2:49 PM, he stated he had received a call from his dispatch that a woman was trying to enter the building. Dispatch had received the call from a worker inside the school building. The officer then made contact with R1 and was able to determine she had eloped from the facility next to the school, and he contacted the facility to inform them of her being in his custody until they could retrieve her. He added that he did not see R1 leave the facility, no one was following her and that he did not know how long she had been out of the facility.

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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 review of facility policy, record review, interview, and observation, the facility failed to ensure a safe environment and failed to provide adequate supervision to prevent elopement for 1 of 5 residents reviewed for elopement risk (Resident (R)1), a cognitively impaired resident with dementia and an inactive wander guard in place. This failure allowed R1 to exit the facility unsupervised through an unlocked front entrance on 05/22/26. On 06/02/26 at 6:05 PM, the Administrator was provided a copy of the CMS Immediate Jeopardy (IJ) Template and notified that the facility had failed to prevent Resident (R)1's elopement which occurred on 05/22/26, creating a reasonable expectation that serious injury, harm, impairment, or death could have occurred, constituting IJ. The IJ was related to 42 CFR 483.12 - Quality of Care.The facility provided an acceptable plan for removal of the IJ on 06/02/26 at 7:34 PM. The survey team validated the facility's corrective actions and determined the facility put forth due diligence in addressing the noncompliance, the SA is considering this IJ at Past Non Compliance as of 05/23/26.An extended survey was conducted in conjunction with the Complaint Survey for non-compliance at F689, constituting substandard quality of care.Findings include:ˆ ˆReview of the facility's undated policy titled, Exit Seeking/Elopement Policy and Procedure identified, Definition of Elopement: Any resident who has left the building UNWITNESSED and is found to be past the RNC [Ridgeland Nursing Center] parameters. Parameters include: a. past the flower bed of the front door to the oak trees of hospital yard. b. past the fences at each end of the building to property line. c. past the dumpsters at the back of the building to the church yard. Review of R1's admission Records revealed she was admitted on [DATE], with diagnoses including but not limited to, intracerebral hemorrhage, dementia, mild protein calorie malnutrition, adjustment disorder with mixed anxiety and mood disorder. Review of R1's Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 05/12/26, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating the resident was unable to complete the interview. Review of R1's record revealed a referral dated 05/11/26 from the hospital for long-term care placement due to increased confusion with orientation to self only, noting she was confused and restless at baseline. Review of R1's elopement risk evaluations dated 05/13/26 and 05/22/26 revealed scores of 8 and 14, respectively, indicating high risk for elopement. Review of R1's physician orders revealed an order for Wander Guard placement to the left ankle 05/13/26 with checks to be documented on each shift. Review of the R1's record did not identify routine Wander Guard checks every shift. Review of R1's care plan revealed a focus area, ELOPMENT: The resident is an elopement risk/wanderer r/t Disoriented to place, Impaired safety awareness, Resident wander aimlessly, with an initiation date of 05/12/26. Interventions included assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, identify pattern of wandering, monitor for fatigue and weight loss, provide structured activities, and Wander Guard to left leg. There was no update to the care plan when 15-minute checks were implemented on 05/21/26 following identification the Wander Guard was not working, as indicated in the progress notes. A review of R1's care plan revealed a focus area, The resident has impaired cognitive function and impaired thought processes r/t Dementia, Impaired decision-making, Short-term memory loss, with an initiation date of 05/12/26. Interventions included medication and monitoring side effects and effectiveness, communication regarding resident capabilities and needs, communication, cues and reorientation, and a consistent routine. The facility complaint survey completed on 05/13/26 identified noncompliance regarding elopement. Review of the facility investigation included a timeline of the elopement, staff statements, and a document outlining R1's 15-minute checks as follows: Review of the facility documented titled, Resident Elopement Timeline - 5/22/2026, revealed, Approximately 5:00 AM. [Certified Nursing Assistant (CNA)EE] checked on resident [R1]. Resident was observed in her room (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	asleep/in bed. [CNAGG] stated the resident was asleep in her room when morning rounds began around 5:50 AM. Approximately 6:00 AM. [Licensed Practical Nurse (LPN)AA] documented that the resident was last observed asleep in her room before beginning wound care on another resident. Approximately 6:15 AM. Staff were informed/called that the resident had been seen across the street near Polaris school. An officer was contacted/responded regarding the resident's location. 6:31 AM. DON [Director of Nursing] notified of resident elopement per nursing note documentation. Between 6:55-7:00 AM. One of the CNAs met with the responding officer to assist in securing the resident. Resident was safely returned to the facility by CNA and responding officer. Upon return to the facility. Nursing assessment completed by nurse. No adverse finding noted.7:00 AM Administrator and physician notified of elopement. Review of the police report from the Ridgeland Police Department dated 05/22/26 05:59:03 revealed, Incident. Incident Nature: Suspicious Person. Occurred From: 05/22/2026 05:58:44. Occurred To: 05/22/2026 05:59:08.Narratives. Supplemental Narrative 06/02/2026 14:41:38. On May 22, 2026, at approximately 0559 hours, [NAME] County Communications received a call from a school cafeteria employee reporting an unknown adult female on school property attempting to gain entry into the building prior to student arrival. The caller advised the female, described as a Black female wearing pink pajama pants and a gray/black tank top, was observed hiding in bushes near the school, pulling on exterior doors, looking through windows, and attempting to enter through the kitchen and main entrance doors. The caller stated the female did not appear to be a student and appeared to be older in age. Throughout the incident, the caller provided real-time updates on the female's movements around the campus. The female was observed entering and exiting through a front door area, walking around the building, checking windows, and repeatedly pulling on locked doors. Officers responded and made contact with the female. Based on the officer's observations, EMS was requested for an altered mental status evaluation at approximately 0616 hours. Further investigation revealed the female was identified as [R1], a resident of a local nursing facility. Contact was made with the nursing home, and staff initially believed Ms. [NAME] was in her room. After being advised she was located at the school, nursing home staff responded to meet with officers. The incident was resolved without reported injuries or criminal activity. EMS evaluated the subject, and appropriate arrangements were made with nursing home staff. Review of the document outlining R1's 15-minute checks revealed that the 15-minute checks began on 05/21/26 at 2:30 PM and continued every 15 minutes throughout the night and the morning of 05/22/26. The document revealed the resident was walking hallways between 2:30 PM 4:30 PM and again from 5:15 PM to 6:00 PM. R1 was noted to be sleeping between 6:15 PM and 9:00 PM with the exception of restroom documented at 7:30 PM. These timeframes did not have staff names or initials to identify who completed the checks. Licensed Practical Nurse (LPN)AA's documentation (identified by her initials) began with her documenting sleeping from 9:15 PM through 5:45 AM on 05/22/26. LPNAA then documented at 6:00 AM, Check (in room) on pt.before starting wound care [LPNAA initials]. Across the lines designated for 6:15 AM and 6:30 AM, were the words *Pt Eloped!!!* The line designated for 6:45 AM was blank. LPNAA documented Vitals check at 7:00 AM. The 15-minute checks continued to be documented through 05/23/26 at 6:15 AM despite the resident having been placed on one-on-one supervision on 05/22/26 between 7:00 AM and 7:59 AM. According to the police report, R1 could not have been at the facility at 6:00 AM as the facility documented on the 15-minute check log. During an observation on 06/02/26 revealed the distance from the facility's front door to the school parking lot was counted at approximately 100-120 steps, depending on the specific place/door of the school building. The distance from the front door to the highway was approximately 115-130 steps where a 55 mile-per-hour sign was observed to be posted. Review of a document titled Ad Hoc Quality Assurance & Performance Improvement Meeting, dated 5/22/2026 revealed, a column titled Opportunity for Improvement, contained, Resident exited the facility without staff knowledge. The second column titled Data., contained, Resident exited the facility without staff knowledge. The resident was able to exit out of the front lobby door without (continued on next page)

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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	staff knowledge. The resident was returned to the facility 5/22/2026.the third column titled Analysis. contained, Based upon root cause analysis to include staff interviews and observation of the front lobby door, the resident was able to exit out the front lobby door without staff knowledge. r/t (related to) the below: Malfunction of the front lobby door. Resident not placed on 1:1 (one-to-one) supervision when Wander Guard malfunctioned. Q (every) 15 min (minute) checks. Wander guard door not receiving power from fire panel. Review of R1's progress note dated 05/18/26 at 2:44 PM revealed, Residents wandering around the unit all day long was able to re-direct for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. Review of R1's progress note dated 05/19/26 at 1:35 PM revealed, She continues to wander but can be redirected for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. Review of R1's progress note dated 05/19/26 at 3:03 PM revealed, Residents wandering around the unit all day long was able to re-direct for meals. There was no indication of staff interventions attempted besides mealtimes to address wandering. Review of R1's progress note titled, Orders - Administration Note, dated 05/21/26 at 2:30 PM revealed, WANDER GUARD to left ankle MONITOR/CHECK PLACEMENT QSHIFT every shift inactive, .15 minute monitoring initiated. Review of R1's progress note titled, Orders - Administration Note, dated 05/22/26 at 1:44 AM revealed, WANDER GUARD to left ankle MONITOR/CHECK PLACEMENT QSHIFT every shift Wander Guard inactive: 15 minute monitoring initiated. [LPNAA typed initials]. Review of a progress note titled, Nurses Note, dated 05/22/26 at 7:00 AM by the Director of Nursing (DON) revealed, Pt has been placed on 1 on 1 for exiting the center without staff knowledge. Review of a progress note titled, eINTERACT SBAR (Situation, Background, Assessment, and Recommendation) Summary for Providers, dated 05/22/26 at 7:21 AM revealed, The Change In Condition/s reported on this CIC (Change of Condition) Evaluation are/were: Other change in condition.Outcomes of Physical Assessment: Positive findings reported on the evaluation for this change in condition were:.Nursing observations, evaluation, and recommendations are: Pt (patient) exited building without staff being made aware through front door, pt (patient) was placed on 1 on 1, no changes noted. Primary Care Provider Feedback:.A. Recommendations: Pt (patient) need 1 on 1 sitter until further notice. Review of a progress note titled Nurses Note and dated 05/22/26 at 7:28 AM by LPNAA revealed, This nurse last observed the patient asleep in her room at around 0600am, before I started wound care on another patient. As I was wrapping up care on my wound patient, the CNA came to inform me that the patient had eloped and was across the street at the Polaris school and an officer had called to inform us of this information. One of the CNAs met with the officer to secure the patient, and they both returned the resident safely to the facility. Upon return to the facility, this nurse assessed the patient - no adverse findings.The DON notified of elopement at 6:55am. The Administrator and MD (medical doctor) notified of elopement at 7:11 am. The RP (responsible party) notified of elopement at 7:42 am. Care ongoing per patient's orders. The timeline documented by LPN AA does not match the elopement timeline documented and provided by the Administrator. Review of a progress note titled Nurse Note by LPNAA, dated 05/22/26 at 7:59 AM revealed, Per Administrator, patient will have 1:1 care. Review of an elopement reported dated 05/22/26 by the DON revealed, Staff was notified by Polaris elementary school's [NAME] [sic] (SRO) School Resource Officer) officer that pt has gotten out of facility without staff knowledge.Pt states she was ready to go.Pt has been placed on 1 on 1 until further notice . No injuries observed at time of incident. The boxes next to Oriented to person and Oriented to Place were checked. The boxes next to Confused and Impaired Memory were also checked. The box next to Sensor Alarm was in Place was checked. The report also included the date and times of notification made to the DON, the physician, the family member, and the administration, and by whom the notifications were made. Review of Certified Nurse Aide (CNA)GG's statement dated 05/22/26 revealed, I witness [sic] [R1] in her room sleep [sic] when I started my rounds at 4am. When I went to change my last resident, [R1] was still in her room at 5:50a. When I walked out the residents [sic] room to continue charting, the town called stating [R1] was across the street at Polaris with an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	officer (6:15 am). Resident was returned safely to the facility by CNA and officer. Review of CNAEE's statement dated 05/22/26 revealed, I [CNAGG] got check [sic] on [R1] at 5:00am before I started my round, she was in her room safe and sound. I continue [sic] giving patient care to my other residents as I was walking out the room to give care to my next resident my coworker then told me to go and get the nurse because the police was [sic] on the phone because [R1] was across the street at the school. Review of CNAKK's statement dated 05/22/26 revealed, I was in the middle of walking the premises when my coworker informed me of one of the residents escaped. I immediately tried to help any way I could, but my coworkers had it under control at that point in time. I returned to document my patrol. CNAKK said he had been performing fire watch duties. Review of R1's progress note titled, Orders - Administration Note, dated 05/23/26 at 1:44 PM revealed, WANDER GUARD to left ankle MONITOR/CHECK PLACEMENT QSHIFT every shift inactive, 15-minute monitoring in effect. This was following the order for one-on-one supervision. During an observation on 06/02/26 at 9:00 AM, the front door was observed to be unlocked. During an observation on 06/02/26 at 8:00 PM, the front door was observed to be locked, and a code was required to exit the facility. During an interview with the Administrator on 06/02/26 at 9:30 AM, he said, Yes, she got out and went next door to the school resource officer. When inquiring about the facility's investigation and other requested documents, he stated, They were so close together. We have combined all of the information for both elopements into this book, which was a red, three-ringed binder. He said that initially, the front door was on a timer that automatically locked them between the hours 7:00 PM and 7:00 AM. After R1's elopement, they changed the lock schedule from 7:00 PM to 8:00 AM, and he showed this surveyor the device to set the times within a panel near the front door. He stated that this was all related to the fire alarm system that had been dysfunctional since approximately October or November for which the facility had a plan in place and was performing 24-hour fire watch monitoring. He further stated that he had personally checked the door before he left on 05/21/26. Review of the Ridgeland Nursing Center Exit Door Daily Log indicated, If the doors are not locked at anytime (sic) ACTION needs to be taken immediately and report to the Administrator. The log identified eight exit doors throughout the facility to be checked, including the Front Exit Door. There were columns that were to be completed for each door: Date; Time Checked; Locked (to be marked if true); Not Locked (to be marked if true); Name Print; and Signature. On the document dated 05/21/26, there were check marks for all doors except the Front Exit Door at 10:00 AM. The front door was not check-marked. The other doors check-marked by the Administrator failed to identify whether the door was locked or unlocked and did not print or sign their name in the corresponding columns, rather the Administrator and the DON initialed/signed below the check marks. The document dated 06/02/26 at 7:00 AM revealed all doors were check-marked locked and signed by the Maintenance Director with a note, All doors are locked. Front entry door & exit door by laundry Wonder [sic] guard not working on these (2) doors. Several documents dated 05/10/26 through 05/22/26 revealed that the front door was check-marked locked during times it was scheduled to be unlocked (7:00 AM to 7:00 PM) and, on each document, all eight (8) doors were check-marked as being checked at the same time. Several documents dated 05/23/26 through 06/02/26 revealed that the front door was check-marked locked during times it was scheduled to be unlocked (8:00 AM to 7:00 PM) and, on each document, all eight (8) doors were check-marked as being checked at the same time. During an interview with R1's family on 06/02/26 at 2:29 PM revealed, The facility has no safety protocols. She said that they had recently updated and added door locks and . they don't have people at the front (entrance) and are short-staffed. No one is at the main entrance, the front, and said any random person can enter. During an interview with CNAGG on 06/02/26 at 3:37 PM, she said she was on duty the night of 05/21/26 through the morning of 05/22/26, during the 11 PM to 7 AM shift along with CNAEE and LPNAA, stating, [CNAEE] was assigned to [R1]. She said she was not assigned to R1 during the shift, but that she checked on R1 at 5:50 AM on behalf of CNAEE. CNAGG stated that she answered the phone at approximately 6:00 AM and discovered that R1 was with the officer at the school next to the facility. CNAGG informed the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurse immediately who was providing wound care to another resident. CNAGG said R1 had been on 15-minute checks because the Wander Guard was not working. R1 had been asleep the entire night and had not exhibited any signs of wandering or elopement. CNAGG was then sent over to retrieve R1 from the officer which took a little while. When she and R1 returned, R1 was immediately placed on one-to-one supervision. During an interview with CNAEE on 06/02/26 at 4:35 PM, revealed she was on duty and assigned to R1 on the night of 05/21/26 through the morning of 05/22/26, during the 11 PM to 7 AM shift. She said she documented 15-minute checks throughout the night because R1's Wander Guard was not working. She said she had begun her 5 AM rounds, and I documented she was in bed at 5:50 AM. During an interview with the Administrator on 06/02/26 at 6:30 PM, he stated, I was not aware that the fire alarm was causing issues or lack of power to the Wander Guard doors. As we tested them prior to, they were working appropriately as evidenced by me checking personally. These checks were on the logs from 05/10/26 through 5/21/26, prior to [R1's] elopement. If the facility had been aware this was an issue, a guard would have been placed at the door to ensure the safety of the residents as was placed when facility became aware. Referring to both elopement events (05/13/26 and 05/22/26) and asked about other sources of supervision aside from the Wander Guard devices, the Administrator stated, They were two totally separate issues. The initial plan included assessing residents for elopement risk and implementing a plan to prevent elopements based upon their assessment outcomes which were completed. The resident on the second elopement risk had already been identified as an elopement risk. Her elopement occurred as the result of a mechanical failure. She had interventions in place already to include the Wander Guard and q15 checks. In all assessments, the facility for elopement risk goes through the interdisciplinary team which provides interventions that are least-to-most restrictive, if warranted by the resident's medical condition and under the direction of the physician. In her situation, we did that. The team met, determined the least restrictive safety prevention measure for the resident to include being placed on one-to-one as the final measure. During an interview with LPNAA on 06/03/26 at 7:55 AM, revealed CNAEE had been assigned to R1's care throughout the night and that she and CNAGG alternated checking on R1 throughout the night as well. Just before LPNAA completed her check, CNAGG had completed a check of the resident. LPNAA performed a check of the resident just before 6:00 AM on 05/22/26. During both checks, the resident was noted to be in bed and asleep. LPNAA then went to another resident's room to provide wound care. CNAEE then entered the room of the resident for whom LPNAA was providing wound care and notified R1 had been found at the school. LPNAA stated she had no responsibility to complete door alarm checks, but that Wander Guard checks are performed each shift. She had learned from the nurse on the previous shift that R1's Wander Guard was not working, and that was the reason she was on 15-minute checks. She did not know why the Wander Guard was not working, but it was still not working at the beginning of her shift. During an interview with the school resource officer on 06/03/26 at 2:49 PM, he stated he had received a call from his dispatch that a woman was trying to enter the school building. Dispatch had received a call from a worker inside the school building. The officer then contacted R1 and was able to determine she had eloped from the facility next to the school, and he contacted the facility to inform them of her being in his custody until they could retrieve her.On 06/02/26 at 7:34 PM, the facility provided an acceptable plan for removal of the IJ, which included the following:Criteria One:1. The identified resident exited the center 5/22/2026 without staff knowledge through the front door was not locked. Resident returned safely by staff and Law Enforcement and placed on 1:1 supervision 5/22/2026 at 7am.2. Change in Condition completed on 5/22/2026.3. Skin assessment completed on 5/22/2026.4. Pain assessment completed on 5/22/2026.5. Risk Management completed on 5/22/2026.6. Psych Services consulted on 5/22/2026.7. Physician notified on 5/22/2026 8. Responsible party notified on 5/22/2026 .Criteria Two:9. A staff member assigned to sit at front door 24/7 started 5/22/2026. Removed on 05/31/2026.10. Front door assessed by outside vendor on 5/22/2026. The Dietary Door is repaired as of 05/27/2026 .11. Identified resident's elopement risk assessment updated on (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/22/2026.12. The dietary exit door to the outside was not working properly and repaired by . on 05/24/2026. Education to the dietary staff on 05/22/2026 by the Maintenance Director.13. The Front door auto lock was changed . on 05/27/2026 from 7p-7a to 7p to 8am. Administrator and DON checked all wander guard doors, and all are locked down correctly. Checked 06/01/2026 and 06/002/2026 [sic] .14. Identified resident's elopement risk care plan was updated to include 1:1 supervision 5/22/2026 15. 100% of all current residents were reassessed for risk of elopement completed on 5/22/2026 16. CPs and orders reviewed and current for residents at risk for elopement as of 5/22/2026 .17. 100% facility head count of current residents completed immediately . All resident are present.18. A second facility wide head count of current residents completed on 5/22/2026. All residents are present.19. Residents who identified at risk for elopement wander guards were checked for placement and function by Director of Nursing on 5/22/2026 Criteria Three:20. Maintenance to check all doors to ensure proper functioning to be completed by 5/22/2026 .21. A licensed nurse to complete a head count of all residents upon arrival and before leaving five times a week . initiated 5/22/2026.22. Maintenance to check all facility doors to ensure proper functioning twice a day x 3 days initiated 5/22/2026 .23. Maintenance/designee to check all facility doors to ensure proper functioning 7 days per week initiated 5/25/2026 24. VP of Clinical Services completed education with Director of Nursing and Executive Director r/t the Elopement policy .25. Facility education for current staff r/t the Elopement policy . initiated 5/22/2026. Staff reeducation began on elopement on 06/02/2026.26. Ad hoc QAPI meeting with the CNO and IDT team to review Safety Plan to be completed 5/26/2026 .27. Ad hoc QAPI Meeting to include a Root Cause Analyses with IDT team . to be completed 05/22/26 .28. Facility to conduct Code Orange Drills daily x 5 days . initiated 05/22/26 . 87 out of 87 employees. Empeon Blast has been sent for Fire Watch and Elopement 29. Facility to conduct unannounced drills 3 x a week . initiated 05/22/2026 . 30. Residents at risk for elopement have names and photos in a binder at the reception desk and nursing stations are at 100% as of 5/22/2026.31. Staff education on elopement and missing residents to be completed annually and upon hire .32. Resident Council Meeting held to . 05/25/2026.33. Residents to be evaluated for risk of elopement upon admission, re-admission, and/or significant change. 34. Staff completing fire watch re-educated on how to identify a nonfunctioning door and report it to the ED . re-educated 5/22/2026 .35. Immediate Federal Reporting completed 05/23/2026 .36. Timeline of events 05/23/26 . Approximately 6:15AM Staff were informed/called that the resident had been seen across the street .37. Staff interviews initiated 05/23/2026 .Criteria Four:38. The results of the quality checks will be reviewed with the QAPI Committee Monthly for further follow up and recommendations as indicated.39. Date of Correction for the Immediate Plan Correction is May 23, 2026.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on review of facility policy, record review and interview, the facility failed to develop and implement approaches to maintain a Quality Assurance and Performance Improvement (QAPI) program to prevent repeat deficiencies. Cross Reference F689Findings include:ˆ Review of the Summary Statement of Deficiencies, for a complaint survey on 05/13/26, indicated the facility was cited at Immediate Jeopardy-F689 when a resident eloped from the facility. Review of facility policy dated 08/01/23 and titled, Policies and Procedures. Subject: Quality Assurance Performance Improvement Program (QAPI), revealed, . Leadership: The Center Executive Director is accountable for the overall implementation and functioning of the QAPI program. This includes but is not limited to: a) implementation b) identifying priorities c) Ensure adequate resources d) Ensures performance indicators, resident and staff input and other information is used to prioritize problems and opportunities e) ensure corrective actions are implemented to address identified problem in systems f) evaluates the effectiveness of actions g) Establishes expectations for safety, quality, rights, and choice and respect. 4. The program is a coordinated effort among departments and services within the organization that involves leadership working with input from Center staff, residents, and families.Data Collection Systems and Monitoring: The center will collect and monitor data from different departments reflecting its performance. The center will identify data sources and timeframe for collection.13. The center will review and develop corrective actions on medical Errors and adverse Events.Identifying Quality Deficiencies and Corrective Action: The center will monitor department performance systems to identify issues or adverse events. 15. If a quality deficiency is identified, the committee will oversee the development of corrective action(s). Review of facility policy dated 10/14/25 and titled, Elopement - Wandering Risk, revealed, Policy: To evaluate and identify residents that are at risk for elopement and develop individualized interventions. Procedure: . (10). Review trends of elopement drills by the QAPI team as indicated. Review of the facility policy dated 04/24/25 titled, Incidents and Accidents, revealed, Definitions: Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented; corrective actions are taken to prevent recurrences and improve the management of resident care. Conducting root cause analysis to ascertain causative/contributing factors as part of the Quality Assurance Performance Improvement (QAPI) to avoid further occurrences. Alert risk management and/or administration of occurrences that could result in claims or further reporting requirements. Meeting regulatory requirements for analysis and reporting of incidents and accidents. Review of a 24-page untitled documented identified by the Administrator as all the QAPI meeting minutes related to the elopements, the header section of the document revealed, Center Stabilization Plan Last Updated: 05/18/2026 Center: Ridgeland Nursing and Rehabilitation Center, LLC. SFF . No. Last Annual Survey: May 2025. The body of the document revealed, Weekly ADHOC Mtg (meeting) on Tuesdays Full QAPI Review 03/31/2026, 04/28/2026, 05/12/2026, with columns labeled, Item/Goal. Action. Person. Target Date. Follow Up. Comment. There are headings for each topic as follows: Operations and Clinical. Administration. Business Office. Admissions. Clinical. Medical Records. MDS. Pharmacy. Therapy. Grievances. HR. Education. Social Services / Activities. Physical Plant - Maintenance. Housekeeping / Laundry. Dining Services. Within the section Operations and Clinical, the Item/Goal: G+ Citations: indicated Action: F696 [sic] Accidents hazards Abated 5/13 (05/13/26) Lowered to a D (scope and severity rating) Contained in the section titled, Physical Plant - Maintenance, the item/goal identified as Elopement Drills identified the action as Elopement Drills have been conducted by the Nursing administration since I have been at RNC (Ridgeland Nursing Center) with the person identified as [DON], and target dates listed as (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	is identified as missing. 4. Staff should report to the nursing station of the missing resident. 5. The licensed nurse assigned to that resident is the lead during the drill and/or actual missing resident response. 6. The licensed nurse will get the elopement binder, remove the search grid sheet and assign staff areas to begin looking for the missing resident. 7. When the resident is located staff are to return the resident to the assigned nurse for evaluation and further reporting / documentation process per regulation. 8. Code orange all clear is then called 3 times to alert staff the missing resident has been located. During an interview with the Administrator on 06/02/26 at 9:30 AM, referring to the initial request for documents, he stated, They were so close together, we have combined all of the information for both elopements in this book, which was a red, three-ringed binder presented in response to the initial document requests. During an interview and observation with the Administrator on 06/02/26 at 11:00 AM, revealed the facility has been having issues with the fire alarm panel since November 2025, and they have been utilizing fire watch to ensure safety until the entire system can be replaced. He said that fire watch consisted of an assigned staff walking around building and monitoring for signs of fire 24 hours per day and 7 days per week. This is and will be ongoing until the state removes it. He said pull tabs are, hit and miss when they work. When asked if he knew this issue had the potential to impact the Wander Guard system, he said, No. I thought it was a completely separate system. And I know it is now. During an interview with R1's family on 06/02/26 at 2:29 PM revealed she is a nurse, and she stated, The facility has no safety protocols. They recently updated and added locks but the don't have people and the front and are short-staffed. She said no one is at the main entrance, the front, and said any random person can enter. During an interview with the Administrator on 06/02/26 at 6:14 PM revealed that one would know individual Wander Guard devices were not working if a red light was not found to be flashing when checked. He said that the doors are checked with a Wander Guard/AccuTech test device daily, starting on 05/10/26. The failure of the door alarm system as related to the Wander Guard device was discovered when the technician came to inspect the system on 05/22/26 (following R1's elopement). It is not currently in policy but is in the Quality Assurance (QA) tool that was created following the recent previous elopement and has been trained on. He said there are no parameters identified on an elopement risk assessment to indicate which interventions to place according to the score of the assessment, that each intervention is determined by the IDT. When asked about resident supervision and there being two incidents of elopement in a 12-day period, the Administrator said, They were two totally separate issues. The initial plan included assessing residents for elopement risk and then implementing a plan to prevent elopements based upon their assessment outcomes which was completed for both residents. [R1] had already been identified as an elopement risk. Her elopement occurred as a result of a mechanical failure. She had interventions in place already to include the Wander Guard and 15-minute checks. In all assessments, the IDT provides interventions that are least restrictive to the most restrictive. If warranted by the resident medical condition under the direction of the physician, and in this situation, we did that. (However, they admitted the 15-minute checks were not appropriate, and the resident should have been on 1:1 as this contributed to the cause of the elopement, along with an unlocked front door.) The team met, determined the least restrictive safety prevention measure for the resident to include one-to-one as the final measure. I was not aware that the fire alarm was causing issues or lack of power to the Wander Guard system on the doors. If the facility had been aware this was an issue, a guard would have been placed at the door to ensure the safety of the residents as was placed when the facility became aware.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425132	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeland Nursing Center Inc	1516 Grays Highway Ridgeland, SC 29936

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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee included active and meaningful participation by the Medical Director in the facility's Quality Assurance and Performance Improvement (QAPI) program. This had the potential to affect all residents in the facility. Findings include:ˆ Review of facility policy dated 08/01/23 and titled, Policies and Procedures. Subject: Quality Assurance Performance Improvement Program (QAPI), revealed, . 6. QAA Committee members include but are not limited to: . b) Medical Director / designee . Review of the facility document titled, Quality Assessment Performance Improvement, dated 05/27/26 at 2:11 PM, identified a pre-populated list of mandatory committee members. Under the column titled Name, next to the pre-populated title Medical Director, the handwritten notation VIA Phone Text was documented. However, on the adjacent column designated for Signature, a handwritten signature was present on the Medical Director's line, creating a conflicting record regarding the Medical Director's actual physical presence and participation in the meeting. The lack of active governance was evidenced by a review of the document titled Ridgeland Safety Plan-Missing Resident. The record indicated the plan was initially implemented on 05/22/26 following a resident elopement; however, a handwritten notation at the top of the page stated, ADHOC QAPI. [Name of Medical Director] Notified of [triangle symbol representing changes] 5/27/26 @ (at) 2:18 PM. This timeline demonstrates that the facility operated a safety plan for five days without the Medical Director's input. The 2:18 PM notification time documented on this document compared with the 2:11 PM QAPI meeting document's start time confirms that the Medical Director was sent an after-the-fact text message summarizing pre-determined revisions, rather than actively participating in the development and approval of the QAPI process. There was no evidence presented to indicate that the Medical Director engaged in meaningful participation in the QAPI/QAA meetings. ˆ