

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445165	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER Highlands Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3549 Norriswood Memphis, TN 38111	
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, Administrator job description review, Director of Nursing (DON) job description review, National Weather Service website review, medical record review, facility video footage review, facility investigation review, hospital record review, and interview, the facility failed to ensure a safe environment and provide adequate supervision to prevent an incident of elopement for 1 of 3 (Resident #1) sampled residents assessed to be at risk for wandering and exit seeking behaviors. Immediate Jeopardy was identified when Resident #1 a vulnerable and cognitively impaired resident with a history of wandering behaviors, exited the building without staff knowledge or assistance on 1/31/2026. Resident #1 walked past the receptionist and followed a visitor through the first set of doors, passed a housekeeper, walked out the second set of doors, and exited the front entrance of the facility, with an outside temperature of 21 degrees Fahrenheit, without a coat or layered clothing, and traveled approximately 3 miles along ice- and snow-covered walkways and roads and across a 4-lane busy intersection. Resident #1 was picked up at an unknown time, in a private vehicle driven by an unknown person, and taken to a family member's home, where he fell on an icy surface while exiting the vehicle. The facility was not aware Resident #1 had exited the building without staff knowledge or assistance until a family member notified the facility at 11:30 AM, approximately 42 minutes later. Resident #1 was returned to the facility on 1/31/2026 at 1:40 PM, by facility staff in a private vehicle. After returning to the facility, radiology (Xray) results revealed Resident #1 sustained an acute intertrochanteric fracture of the right hip (a break in the long bone of the upper leg), was transferred to the hospital from the facility on 1/31/2026 and underwent a surgical repair on 2/1/2026. The facility's failure to supervise Resident #1 placed the resident and all residents with wandering behaviors in Immediate Jeopardy. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident. The Administrator, the Regional Nurse Consultant, and the Director of Operations were notified of the Immediate Jeopardy (IJ) on 2/5/2026 at 3:02 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited at F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ began on 1/31/2026 and continued through 2/3/2026. The IJ was removed on 2/4/2026 when the facility implemented a corrective action plan. The corrective actions were validated by the surveyor on 2/10/2026. The IJ was cited as past noncompliance for F-689 and the facility is not required to submit a Plan of Correction. The findings include: 1. Review of the undated facility's policy titled, Elopement and Wandering Residents, revealed .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .The facility is equipped with door locks/alarms to help avoid elopements. Alarms</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 445165	Facility ID: 445165 If continuation sheet Page 1 of 7

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>are not a replacement for necessary supervision. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. 2. Review of the Administrator job description dated 6/25/2023, revealed .govern nursing facilities to assure that the highest degree of quality of care can be provided to our residents at all times. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility. Ensure that all employees follow the established policies and procedures. Assume the administrative authority, responsibility, and accountability of directing the activities and programs of the facility. Review of the undated DON job description, revealed .plan, organize, develop and direct the overall operations of our Nursing Service Department. to ensure that the highest degree of quality of care is maintained at all times. Develop methods for coordination of nursing services with other resident services to ensure the continuity of the resident's total regimen of care. 3. Review of the National Weather Service.gov website dated 1/31/2026, revealed the temperature was 21 degrees Fahrenheit at 10:54 AM for the area where the facility was located. 4. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Wedge Compression Fracture (a fracture to the front part of the vertebra), Malnutrition, Traumatic Subarachnoid Hemorrhage (a critical brain injury caused from bleeding), Psychotic Disorder, Gastrostomy (a tube inserted directly into the stomach used for nutrients or medications), and Dysphasia. Review of the Care Plan dated 12/18/2025, revealed .a behavior problem. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Resident #1's Care Plan did not address his wandering behaviors or interventions to address wandering until after an incident of elopement occurred on 1/31/2026. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was severely cognitively impaired. Resident #1 exhibited wandering behaviors for 1 to 3 days of the 7 day lookback period. Resident #1 required moderate assistance of staff when ambulating at least 10 feet. Review of the Nurse's Note dated 1/1/2026 at 8:36 PM, revealed Nursing Summary: pt. [patient-Resident #1] alert and verbal, He's able to make most of his needs known verbally. Pt. noted to be exit seeking several times this shift after his (Girlfriend and cousin) left. Wonder [Wander] guard bracelet [a device placed on the person that would sound if near an entrance/exit to alert staff] was put in place to his lower left leg. pt. stated (he was going to get out of here and go home when we were not looking.) pt's POA [Power of Attorney] notified of the pt's exit seeking attempts. Pt's a fall risk and not aware that it is not safe for him to stand up from his w/c [wheelchair] without locking the w/c brakes. He has been educated on why the w/c brakes should be in place and secure before attempting to go from a sitting to a standing position. The pt. just nodded his head as if he understood but he did not, by his actions. Review of the Elopement Risk assessment dated [DATE], revealed Resident #1 scored 31 and was at risk for elopement. Resident #1 was ambulatory/mobile with use of a device, and he was cognitively impaired with decreased safety awareness, disturbances in judgement, a history/risk of wandering, and a history of elopement with one or two elopement events. Further review revealed Resident #1 was .alert and verbal and tried several times to leave the facility this shift. Resident #1 stated he was going home, going to his girlfriend's house, I'm not sick so why am I here, and I'm going home tonight. Review of the Physician's Order dated 1/1/2026, revealed wonder</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>responsible party. During an interview on 2/5/2026 at 8:32 AM, the Administrator was asked when did you initially learn Resident #1 had eloped from the facility. The Administrator stated, RN A called and reported that [Resident #1] had left the facility and went to his sister's house around 11:15 AM, and she was on her way to the sister's house. I spoke with the DON, and she confirmed that a code white was initiated at the facility and a head count was performed of all residents in the facility. I arrived at the niece's house around 11:45 AM, the resident was on the couch with a blanket over him, RN A reported that he was complaining of right hip pain from falling outside. The Administrator was asked how the resident got back to the facility. The Administrator stated, A male family member, the DON's spouse, and myself assisted [Resident #1] to ambulate to the truck, he did not groan or grimace from pain. The Administrator was asked to describe the weather that day. The Administrator stated, the temperature was in the 20's [degrees in Fahrenheit] with snow covered ice over on most of the ground. The Administrator was asked if 911 was considered while at the niece's residence. The Administrator stated, No, we were trying to get him back to the facility for [so] a more thorough assessment could be performed. The Administrator was asked how the resident got out of the facility without staff's knowledge. The Administrator stated, The wander guard was not working properly and failed to alarm when he exited the door. We have since identified and fixed the problem with the wander guard system to improve the system. During an interview on 2/5/2026 at 10:22 AM, the DON was asked if a resident is assessed for wandering behaviors on admission, should they be care planned for wandering behaviors. The DON said yes, they should be care planned for wandering. The DON was asked if Resident #1 was care planned for wandering or exit seeking behaviors prior to 1/31/2026. The DON stated, No, he was not. I added it when I noticed it was left off. The DON was asked should have Resident #1 been care planned before 1/31/2026 for wandering and exit seeking behaviors. The DON stated, Yes, he should have. During a telephone interview on 2/10/2026 at 9:03 AM, the Medical Director (MD) was asked if he expects the facility staff to monitor the functionality of a wander guard for resident exhibiting exit seeking behaviors. The MD stated, Yes, they should. The MD was asked if residents should be care planned if they have wandering or exit seeking behaviors. The MD stated, Yes. The MD was asked what should staff do if the resident was assessed to have increased pain, swelling, and decreased range of motion to an extremity after a fall onsite at a family member's house. The MD stated, Call 911. The facility's corrective actions for the removal plan were issued to the state surveyor on 2/10/2026 and validated while onsite. The corrective action plan included the following: Corrective Actions Implemented for Resident #1 on 1/31/2026 included a medical assessment completed by the charge nurse and notification of Physician/Nurse Practitioner (NP) by the Assistant Director of Nursing. The Physician was notified by the Administrator and pain medications were administered as ordered by the charge nurse. The charge nurse followed physician orders to obtain an X-Ray which revealed an acute fracture of the inner trochanteric right hip, the charge nurse notified Physician/NP, and Resident #1 was transferred to the hospital by the charge nurse. Corrective Actions Implemented for Current Residents Beginning 1/31/2026: a. Verification of resident census with confirmation of all residents present in facility completed by supervisor on duty b. Elopement Risk Assessments were updated on current residents by the Director of Nursing, Assistant Director of Nursing and the unit managers to determine high elopement/wandering risk residents. c. Director of Nursing, Assistant Director of Nursing and the unit managers reviewed and revised care plans for all high elopement/wandering risk residents. 1 resident was identified with a high-risk elopement score when assessed - care plan updated with appropriate interventions including wander guard placement. d. Staff re-education provided on elopement and wandering residents' policy, timely response to alarms, supervision</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>expectations and location of Wander Guard Elopement Risk Binder. The 13 pages of signatures is the education that was started on 1/31/2026 and completed on 2/3/2026, will continue until 100% staff have been educated. Staff will not be allowed to work without completed education. PRN (as needed) staff that could be contacted were educated by phone by Administrator, Director of Nursing, Assistant Director of Nursing and the unit managers. Staff that are on leave will receive education on return to work. The facility does not utilize agency staff. Weekend staff were educated at the beginning of their first shift of work. No staff member has been allowed to work without required education. This education was completed by Director of Nursing, Assistant Director of Nursing and the unit managers/supervisors. e. Administrator revised maintenance procedures for auditing Wander Guard doors to include inspection of Wander Guard alarm panel integrity and hardware. f. Residents assessed as high risk for elopement with wander guard bracelets had information to include pictures and profile placed in the Elopement Risk Binder at the Reception Desk and at each nurses' station. This was completed by the Director of Nursing. g. The Administrator gave 1:1 (one on one) education to the house-keeper present at door at time of the event regarding responsibilities of her job that include recognizing residents that are wanderers and/or at risk for elopement and being observant while working in the exit areas / Receptionist at door quit on the day of the event when she was interviewed regarding the event but did sign education presented by the administrator. h. 1:1 education was provided by the administrator for the Maintenance department to check structural integrity of the wander guard door alarm system in addition to normal testing. i. Elopement Drills were completed starting 1/31/2026 and continue until 100% staff have completed an elopement drill and understand the process. The facility currently does not utilize agency staff. The elopement drills were completed by the Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance and the Unit Managers/Supervisors. j. Wander Guard Alarm testing and door checks including structural integrity will be completed 2 x (times) daily starting 1/31/2026 by Maintenance and/or Administrator. Results will be discussed in QAPI (Quality Assurance and Performance Improvement) monthly x 3 months and monitoring frequency will be evaluated and adjusted according to audit results. On 1/31/2026 a. Maintenance inspected Wander Guard system; front entrance panel identified as loose due to wear and tear and immediately repaired and the system was tested and found to be working correctly. b. The enhanced monitoring was initiated at reception area includes Front Desk Visitor Screening Audit Log and Back Up Monitoring Log were initiated on 1/31/2026 by the Administrator. The Administrator educated the Business Office Manager and the Reception Staff on these monitoring processes starting 1/31/2026 and complete by 2/3/2026. Employees that have not been educated will be educated on first day returned to work. QAPI (Quality and Performance Improvement) meeting held on 1/31/2026 a. Ad Hoc QAPI completed to review the incident, timeline of events, and immediate corrective actions necessary to achieve past non-compliance. b. QAPI team members present including Medical Director. c. Audits Implemented and On-going: Wander Guard Door Alarm Audit, Front Desk Visitor Screening Audit Log d. Wander Guard Alarm testing and door checks including structural integrity will be completed 2 x daily starting 1/31/2026 by Maintenance or designee. Results will be discussed in QAPI monthly x 3 months and monitoring frequency will be evaluated and adjusted according to audit results. The correction has been made on the original Adhoc (Ad hoc) (as needed) QAPI document. On 2/2/2026 a. Inspection and repair of the Wander Guard System by vendor State Systems was complete on Monday 2/2/2026. The invoice was received on 2/3/2026. The Removal Plan was validated onsite by the surveyor on 2/10/2026 which included review of the facility education to show each step was completed, staff interviews to confirm completion, review of care plans, review of new hire orientation training, review of audit logs for completion, and review</p> <p>(continued on next page)</p>		

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