

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Hartsville Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 McMurry Blvd Hartsville, TN 37074	

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>(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
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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility investigation review, medical record review, observation, and interview, the facility failed to provide adequate supervision to prevent 1 of 6 (Resident #1) residents reviewed for wandering behaviors from exiting the building without staff supervision. Resident #1 was a vulnerable, cognitively impaired Resident with a history of wandering behaviors and wore a wander guard on his person and on his wheelchair. On 10/28/2024, an order was written to discontinue the wander guard from Resident #1's wheelchair. The facility discontinued Resident #1's wander guard from his wheelchair and from his person. Resident #1 eloped from the facility on 11/27/2024, 29 days after the wander guard was discontinued from his wheelchair and his person. The facility's failure to ensure a safe, secure environment resulted in Immediate Jeopardy (IJ) when Resident #1, eloped from the facility on 11/27/2024, and was found approximately 0.3 miles from the facility at a discount retail store. Immediate Jeopardy (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) was identified related to the facility's failure to provide adequate supervision of a vulnerable, cognitively impaired resident to prevent an incident of elopement. The Owner, Administrator, Registered Nurse (RN) Consultant, and Director of Nursing (DON) were notified of Immediate Jeopardy on 8/8/2025 at 6:37 PM, in the Conference Room. The facility was cited F689 at a scope and severity of J which is substandard quality of care. The IJ began on 11/27/2024 through 12/5/2024. The IJ was removed on 12/6/2024. The corrective action plan for the IJ was validated onsite by surveyor on 8/11/2025. The facility was cited past noncompliance (PNC) for F-689 and is not required to submit a Plan of Correction. The finding include: 1. Review of the facility policy titled, Elopement and Wandering Residents, dated 4/16/2021, revealed .The facility ensures that residents who exhibit wandering behaviors 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. 'Wandering' is random or repetitive locomotion that may be goal-directed. 'Elopement' occurs when a resident leaves the premises or a safe area without authorization. The facility is equipped with door locks/alarms to help avoid elopements. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team [IDT]. when repeated elopement attempts occur, after the facility has exhausted possible care. Any staff members becoming aware of a missing resident will alert personnel using facility approved protocol. Review of the facility policy titled, Wandering Residents dated 12/6/2024, revealed Every effort will be made to prevent wandering episodes while maintaining the least restrictive environment for residents who are at risk for elopement .All residents at risk for harm because of wandering (elopement) will be assessed by the inter disciplinary care planning team .current MDS [Minimum Data Set] .will be reviewed .The resident's care plan will be modified .All residents at risk for harm because of wandering (elopement) will be placed on first floor with [Named] security ankle monitor placement. Once a wander guard has been placed on a resident, any removable must be approved by the QAPI [Quality Assurance and Performance Improvement] committee. Any resident with a wander guard must be accompanied by sitter, nurse, activity staff or family member to go to 2nd floor. Review of undated facility policy titled, Missing Resident Policy and Procedure, revealed .It is the policy of this facility, that all residents will remain safely contained within the confinement of the building and its perimeter. if a resident is unable to be found, and is suspected to be missing, the nurse in charge of that resident will announce over the intercom: CODE PURPLE. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including dementia, Major Depressive Disorder and Diabetes. Review of Physician's Telephone Orders dated 7/15/2024, revealed an order Per Recommendation of facility Psych [Psychiatric] services may discontinue Wanderguard [Wander Guard]. Review of Physician's Telephone Orders dated 8/12/2024, revealed Nurse Practitioner (NP) I had given an order .Wanderguard to wheelchair . check placement & functionality q [every] Monday . Review of the Intermediate Care Facility (ICF) Behavior Progress Note dated 8/12/2024, revealed Resident #1 attempted to exit the facility door and a wander guard was applied to his wheelchair. Review of Care Plan dated 8/16/2024, revealed .8/13/2024 Behavioral Svmptoms Wander Guard applied for wandering and exit seeking behavior Re-applied to resident's WC.</p>		