STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Oaks Health Care Center	1101 Persimmon Ridge Rd Jonesborough, TN 37659

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 - Minimal harm or potential for actual harm 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** 37078 Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to protect the residents' right to be free from accidents related to an elopement for 1 resident (Resident #6) of 6 residents reviewed for accidents. F689 was cited as past noncompliance and the facility is not required to submit a Plan of Correction. The findings include: Review of facility's undated policy titled, Elopement Risk, revealed .This facility ensures that residents who exhibit unsafe wandering behavior and/or 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 unsafe wandering or elopement risk .Elopement occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so Safe premises refers to the facility and premises or grounds of the property . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Traumatic Hemorrhage of Cerebrum, Fracture of Base of Skull, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 required set up assistance with activities of daily living (ADL's). Resident #6 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment which indicated moderate cognitive impairment Review of the care plan for Resident #6 dated 8/16/2024 and revised on 10/6/2024 revealed .Resident is at risk for elopement [related to] cognitive impairment, exhibits unsafe wandering behaviors, has expressed desire to leave .Resident prepared letter of plan of living arrangements, including monetary means .Resident will be safe in facility and will not exit facility unsupervised .Distract resident from wandering by offering pleasant diversions, structured activities, food . Review of the facility investigation documentation revealed on 10/6/2025 at 12:30 AM, staff became aware Resident #6 was not in the facility. Resident #6 had broken the lock on his bedroom window and exited the building through the window. The resident left a note stating he did not want to stay at the facility any longer. (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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NAME OF PROVIDER OR SUPPLIER Four Oaks Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Persimmon Ridge Rd Jonesborough, TN 37659	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Social Services note dated 10/6/2025 revealed .On October 2nd, 3rd and 4th I [Social Services Director] had conversations with [Resident #6] regarding discharge. He expressed that he wanted to leave the facility .He mentioned that he had secured a place in Kingsport and was going to social security [office] on Monday to get back his check .I advised that if he could wait until Monday, we would try to do the discharge safely. On October 6th, I was notified that [Resident #6] was not in building. Upon arrival and calling police a note was found that stated he had decided to leave .His letter is consistent with the plans he shared with me when discussing possible discharge . During an interview on 2/25/2025 at 12:50 PM, The Administrator stated .[Resident #6] left me a note saying he wasn't going to stay any longer .we called the police and reported he had left, and we showed them the note .he broke the lock on the window with a butterknife and went out the window . During a telephone interview on 2/26/2025 at 8:15 AM, Local Police Sergeant stated .I got the call that somebody had gone missing .[facility staff] gave me some information on [Resident #6] .what we determined is he had escaped through the window . During a telephone interview on 2/26/2025 at 8:45 AM, Resident #6's sister stated .[Resident #6] eloped out of a window, he had a traumatic brain injury in July of last year he couldn't care for himself so we put him in [the facility] .he would call me .I told the police he went to Kingsport because I knew he had so called friends there .I got a call from [physician's office] that said [Resident #6] came by yesterday [2/25/2025] to reschedule an appointment that he had missed I have no idea where he is at now .he doesn't want help .he has made that clear . The facility was cited F-689 as past non-compliance. The facility's corrective actions were validated onsite by the surveyor on 3/5/2025. The corrective action plan included a Root Cause Analysis (RCA) Review of the corrective action plan revealed the following: 1. Corrective action (s) accomplished for those residents found to have been affected by the deficient practice: a. On 10/6/2024, Resident #6 was not present in room. elopement procedures were put into place per policy including searching for the resident, securing exits, performing head count, and notifying local police. Interview with the Administrator, the Director of Nursing (DON), and Maintenance Director on 3/5/2025 confirmed elopement procedure was put into place. b. The resident did not return to the facility. Review of Resident #6's medical record, current facility census, and interview with the Administrator and DON on 3/5/2025 confirmed the resident did not return to the facility. c. On 10/6/2024, the residents' elopement risk assessment and care plan were reviewed by Administrator and information given to police. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #6's risk assessment and care plan revealed the resident was at risk for elopement interview with a local police Sergeant on 2/26/2025 and the Administrator on 3/5/2025 confirmed the information was given to the local police department. d. On 10/6/2024 all windows and doors throughout facility were checked to ensure proper locking mechanisms were in place by the Maintenance Director and the lock on the resident's room was replaced. Observation of the bedroom window Residents #6 eloped through with the Maintenance Director, review of window lock audit dated 10/6/2024, and interview with the Maintenance Director on 3/5/2025 confirmed windows and doors throughout the facility were checked and Resident #6's window lock was replaced. e. On 10/6/2024, all center door codes were changed by facility Maintenance Director. Doors were set to alarm when opened greater than15 seconds. Doors were set to auto lock upon closure. Observation of 9 of 9 doors and interview on 3/5/2025 with the Maintenance Director confirmed all doors were in working order, codes were changed and not visible to the public or residents, and alarms were set and in working condition. 2. Other residents having the potential to be affected by the same practice and corrective actions taken: a. On 10/6/2024 a 100% review of all resident's elopement assessments was completed to ensure resident assessments were up to date and accurate with changes made as needed. All residents care plans were reviewed to ensure the current assessment was reflected appropriately on the care plan. Review was completed by the DON, Assistant Director of Nursing (ADON) and Wound Care Nurse (WCN). Review of facility resident elopement system audit form, care plans, midnight census report dated 10/5/2024 and interview with the DON, and ADON, on 3/5/2025 confirmed the review was completed. 3. What measures will be put into place or what systemic changes were made to ensure that the practice does not recur: a. Facility Administration including Administrator, and Staff Development Coordinator (SDC) began educating all staff on 10/6/2024 and continued educating all staff prior to beginning work their next scheduled shift. Education included elopement prevention, importance of privacy with door code including new system related to only staff having code, and new signage to be placed on front door. Additionally, the Elopement Risk Policy and the Abuse, Neglect, and Exploitation Policy were also presented. To ensure retention, all staff completed a post test that required 100% compliance. If a staff member did not meet 100% compliance, reeducation was completed until threshold was achieved. Any staff member that was assigned as needed (PRN), on Paid Time Off (PTO), or on Family Medical Leave (FMLA) will require education and the post test before their next scheduled shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of two signs at the front entrance to remind people to make sure door lock has engaged and instructions to use the doorbell for staff to open the door, review of facility list of employees, education sign in sheets, and post tests confirmed education was completed on 10/7/2024 interview with multiple staff including Dietary Aide, Social Services, Business Office Manager, Occupational Therapist, Environmental Services Director, Multiple Licensed Practical Nurses (LPNs), Certified Nurse Assistants (CNAs) and 2 night shift CNAs, 1 night shift LPN, and 1 night shift Registered Nurse (RN) confirmed education was completed and the staff were knowledgeable. b. Beginning 10/6/2024 elopement drills were completed on each shift by Maintenance Director and will continue to be completed monthly or as needed. Review of facility elopement drills and interview with the Maintenance Director on 3/5/2025 confirmed elopement drills were completed in 10/2025, 11/2024, and 2/2025. Interview with the Administrator revealed elopement drills were continued quarterly after 11/2024 and were ongoing. c. On 10/6/2024, all outside doors alarms were verified to alarm when open greater than 15 seconds by Maintenance Director. Observation on 3/5/2025 with the Maintenance Director confirmed all outside doors were checked and working properly. d. Window audits will be increased to weekly x4 weeks, then biweekly for 4 weeks until 100% compliance is achieved by Maintenance Director. Audits will then revert to monthly audits. Review of weekly and monthly window lock audit checklist and interview with the Maintenance Director on 3/5/2025 confirmed audits were conducted. 4. Corrective action(s) monitored to ensure the practice will not recur: a. Beginning 10/6/2024, the Maintenance Director will perform manual checks on all windows to ensure latches were secured and doors of the facility had proper function of locks and alarms. These audits will be conducted weekly for 4 weeks, then biweekly for 4 weeks, then monthly as previously required. Any concerns identified will be immediately reported and corrected to the Administrator by the Maintenance Director. Audits will be reviewed in monthly Quality Assurance Performance Improvement (QAPI). Review of QAPI sign in sheets dated 10/6/2024 , 10/28/2024, 12/9/2024, 1/13/2025, and 2/24/2025, Window Lock Audits, Exit Door Locks audits, and interview with the Maintenance Director on 3/5/2025 confirmed the Audits were completed, reviewed monthly in QAPI, and were ongoing. b. Any issues with non-compliance will be presented to the Quality Assessment and Assurance (QAA) Committee (Administrator, Director of Nursing, Medical Director, Assistant Director of Nursing, MDS Coordinator, Social Services Director, Admissions Director, Maintenance Director, Dietary Supervisor, and Environmental Supervisor) for review and resolution. If non-compliance is identified, audits will start back at the beginning occurring weekly for 4 weeks, then biweekly for 4 weeks, then monthly as regularly scheduled. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of QAA sign in sheets dated 10/6/2024, 10/28/2024, 12/9/2024, 1/13/2025, and 2/24/2025, interview with the Administrator and Maintenance Director on 3/5/2025 confirmed meeting was held with the required member and no new noncompliance was identified.