STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Boston Health & Rehab Center	103 Rosehill Drive South Boston, VA 24592

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide adequate supervision and ensure the environment was free of accident hazards to prevent residents from exiting the facility without staff knowledge and resulted resulting in one resident (Resident #3- R3) having eloped the facility for an undetermined amount of time. The deficient practice had the potential to affect residents identified at risk for elopement residing on two of the three occupied units, which resulted in the identification of Immediate Jeopardy (IJ) and substandard quality of care. Immediate jeopardy began on 1/17/25 and when removed on 12/4/25, the scope and severity was lowered to a level two, isolated (D). The findings included: On 12/3/25 at 11:45 AM, R3 was observed in the hallway outside of his room and was observed to self-propel his wheelchair without any staff assistance. R3 propelled himself into his room to converse with the surveyor. When asked about a known elopement that occurred in January 2025, R3 said, That was a long time ago. R3's recall of the events from that incident were not limited and the resident was unable to state where he went, who found him, how long he was gone, the purpose of leaving, or how he returned to the facility. On 12/3/25, a clinical record review was conducted of R3's medical record. This review revealed that R3 had been admitted to the facility on [DATE]. R3's diagnosis included, but were not limited to alcohol abuse, disorientation, anxiety disorder, personal history of nicotine dependence, and other symptoms and signs involving cognitive functions and awareness. According to the assessment completed by nursing on R3's admission, the resident was not identified to be at risk for wandering. On 11/15/24 an Elopement Observation assessment was completed by the director of nursing (DON) for R3. The entry on the assessment read, Wander guard placed d/t [due to] exit seeking behaviors without safety awareness. MD/RP [medical doctor and responsible party] aware. A physician order was entered on 11/19/24, which remained an active order at the time of survey for R3 and read, Safety/Wanderguard: Electronic bracelet for safety-check functioning daily, Special Instructions: Check bracelet functioning daily. On 1/3/25, a nursing note entry in R3's chart read, Wanderguard in place d/t [due to] exit seeking behaviors/wandering. IDT [interdisciplinary] Team. On 1/16/25 at 9:10 PM, a nursing note entry read, alerted by staff of inability to locate resident in either room, on unit or on frequently visited unit, code green called , staffed [sic] stated last visualization was between 1900- 2100 [7PM-9PM], head of count of all active residents, all were accounted for except current resident, code green initiated per policy, after 15 minutes search both within facility and outside grounds, police notified to aid in search and recovery, at this time RP [responsible party] was also notified of resident elopement, RP stated she was on the way to the facility to aid and recovery. Wanderguard to remain in place. IDT Team. According to a nursing note entry dated 1/16/25 at 10:17 PM, it read, Notified by police department at 2217 resident was located behind Tractor Supply, noted to be wearing Navy blue zipped up hoodie, shirt, flannel pajamas pants, socks, green sneakers, black beanie, stated he comes out here all time with his friends and the doctor to told him to get his exercise, voiced no c/o [complaint of] pain or discomfort, alert and orient, able to follow simple commands, shoes and wheelchair wheels covered in dirt, refused to return to facility with police escort, staff and sister left facility to recover resident. On 1/16/25 at 10:30 PM, the nursing staff recorded the following, 2230: resident returned to facility without incident. family present at bedside, VS 98.2 126-22-140/98Larm-95%RA. Thorough head to toe assessment completed with bilateral lower extremities cold to the touch, pulse palpated, pulses strong bounding. No s/sx [signs or symptoms] of hypothermia. Alert and verbal to name. Remains able to follow simple commands with no complaints of pain/discomfort. Staff notified that resident is one on one while awake and 15 minute checks while sleeping. MD [medical doctor] aware of elopement and return to facility. Order received to send to ER [emergency room] for eval and treat. According to a follow-up progress note entry on 1/18/25, the doctor noted, Pt [patient] was missing for an undisclosed amount of time- not specifically 4 hours. Follow-up notes indicate that the resident refused to go to the ER for evaluation. According to additional progress notes following the elopement of R3 on 1/16/25, there was evidence that the facility was attempting to find alternate placement in a secured facility. On 1/17/25, there was a social services progress note that indicated R3 had left on 1/7/25 for a doctor appointment and no alarm went off. On 1/17/25 On 1/17/25, R3 had another Elopement Observation assessment conducted, R3 scored eight, which noted they were at continued risk for elopement. No further Elopement Observations had been conducted at the time of survey since 1/17/25. On 12/4/25 at 8:45 AM