

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255127		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/18/2025	
NAME OF PROVIDER OR SUPPLIER TISHOMINGO COMM LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1410 WEST QUITMAN STREET , IUKA, Mississippi, 38852			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted Annual Recertification Survey along with two (2) Complaint Investigations (CI MS#2596183 and CI MS#2690998) at the facility from 12/15/25 to 12/18/25. CI MS #2596183 was investigated for physical environment with no deficiencies cited. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid for CI MS#2690998 which was investigated for Accident Hazards and F689 was cited at an Immediate Jeopardy (IJ). The SA also cited F628 at a D level and F851 at a F level during the annual survey. On 12/10/25, at approximately 2:53 PM a member of the facility staff reported in the staff meeting that Resident #68 was found inside the pharmacy across the street. At 2:55 PM Resident # 68 was located approximately 100 yards away from the facility across a busy two-lane street inside the pharmacy where he was observed standing, laughing and conversing with the pharmacy staff. The temperature at the time was cloudy and 55 degrees; the resident was dressed in lace up tennis shoes, pants and a long sleeve shirt. The facility's failure to provide adequate supervision to prevent the elopement of Resident #68 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an IJ and Substandard Quality of Care (SQC) which began on 12/10/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) – Scope and Severity (S/S) of "J". The SA notified the facility's Administrator of the IJ and SQC on 12/15/25, at 3:30 PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 12/11/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 12/12/25, prior to the SA's entrance on 12/15/25.			F0000			

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 reverse for further 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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F0000	Continued from page 1 The facility held a license for 73 beds, with a census of 64.	F0000					
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge	F0628					

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F0628 SS = D	Continued from page 2 in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal	F0628					

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F0628 SS = D	Continued from page 3 form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-			F0628			

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F0628 SS = D	Continued from page 4 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide written notification to the resident/representative regarding bed hold when the resident was sent to the hospital for two (2) of two residents reviewed for hospitalization. Resident #1 and Resident #65			F0628			

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F0628 SS = D	Continued from page 5 Findings Include: Review of the facility policy titled, "Bed hold Policy and Procedure" revealed Policy: "Before the facility transfers a resident to the hospital or allows a resident to go on therapeutic leave, written information should be provided to the resident and family member or legal representative specifying the following information: (i) The duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the facility; and (ii) The policies regarding bed-hold periods, which should be consistent ...In the case of an emergency transfer, a written notification should be given to the family, surrogate, or representative within 24 hours of the transfer. A copy of the notice should be sent with the resident in the transferring paperwork." Resident #1 Review of Resident #1's Health Status Note, dated 11/24/25, revealed that the Medical Director (MD) ordered the resident be sent to Emergency Room (ER) for treatment and evaluation." Record review of the "Transfer/Discharge Notice Form" revealed that Resident #1 was transferred/discharged to the hospital on 11/24/25. During an interview on 12/18/25 at 9:25 AM, the Business Office Manager (BOM) confirmed that the facility did not provide a written bed-hold notice to the resident or the resident's representative at the time of transfer. She acknowledged that she is responsible for ensuring the written bed hold notifications are sent to the resident/resident representative when a resident is transferred to the hospital. She confirmed that the bed hold policy, which includes the reserve bed payment, was not sent for Resident #1 and Resident #65. During an interview on 12/18/25 at 10:25 AM, the Administrator confirmed that whenever a resident is discharged or transferred, they are supposed to receive a notification of bed-hold, including the amount, so the resident or resident representative will know how much they will need to pay to hold their bed. Record review of the "Admission Record" revealed Resident #1 was admitted to the facility on 02/10/2021 with diagnoses that include, Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, and Dysphagia.		F0628				

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F0628 SS = D	Continued from page 6 Record review of Resident #1's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9/17/25 revealed Resident #1 is rarely/never understood. Resident #65 Review of Resident #65's Health Status Note, dated 10/08/25, revealed that the MD ordered the resident be sent to ER for treatment and evaluation. Record review of the "Transfer/Discharge Notice Form" revealed that Resident #65 was transferred/discharged to the hospital on 10/08/25. Record review of the "Admission Record" revealed Resident #65 was admitted to the facility on 08/22/2025 with a diagnosis that included Metabolic Encephalopathy. Record review of Resident #65's MDS with ARD of 10/08/25 revealed Resident #65's BIMS was incomplete, as the majority of cognitive interview questions were marked "not assessed," and no BIMS summary score (0-15 or 99) was entered.		F0628				
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to provide adequate supervision and a secure environment to prevent the elopement of one (1) of five (5) residents who were at risk for elopement and wandering, Resident #68. On 12/10/25, at approximately 2:53 PM a member of the facility staff reported in the staff meeting that		F0689	"Past Noncompliance - no plan of correction required"			

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F0689 SS = SQC-J	Continued from page 7 Resident #68 was found inside the pharmacy across the street. At 2:55 PM Resident # 68 was located by facility staff, approximately 100 yards away from the facility across a busy two-lane street inside the pharmacy where he was observed standing, laughing and conversing with the pharmacy staff. The temperature at the time was cloudy and 55 degrees; the resident was dressed in lace up tennis shoes, pants and a long sleeve shirt. The facility's failure to provide adequate supervision to prevent the elopement of Resident #68 placed this resident, and other residents at risk for wandering and elopement, in a situation that was likely to cause serious injury, harm, impairment, or death. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began on 12/10/25 and existed at 42 CFR(s): 483.25(d)(1)(2) Free of Accidents Hazards/Supervision/Devices (F689) – Scope and Severity (S/S) of "J". The SA notified the facility's Administrator of the IJ and SQC on 12/15/25, at 3:30PM and provided the Administrator with the IJ template. Based on the facility's implementation of corrective actions on 12/11/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed as of 12/12/25, prior to the SA's first entrance on 12/15/25. Findings include: Record review of facility "Elopement/Unsafe Wandering Plan" dated 02/07/2012 revealed, "Policy: It is the policy of this facility to protect the resident from harm while providing care in a manner that helps promote quality of life and safe environment...Procedures... Risk Evaluation: An evaluation of the resident's risk for unsafe wandering or elopement is to be conducted on admission, quarterly, after a significant change in condition, and after an incident of elopement. Identification: Residents at risk will have some type of "identifier" on their person... Plan of Care: If a resident is identified at risk for elopement or unsafe wandering, a preventative plan of care is to be implemented at the time the risk is identified. Unsafe wandering and/or elopement potential is to be entered into the ADL (activity of daily living) system and ADL plan of care...Supervision: Visual supervision may be necessary in some instances. The nursing staff will complete and document the visual checks as necessary. Facility Systems: Systems such as			F0689			

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F0689 SS = SQC-J	Continued from page 8 alarms, Wander guard systems and special locks/keypads as allowed by state and local authorities will be utilized to the extent possible..." Record review of the Admission Record for Resident #68 revealed the facility admitted the resident on 12/5/25 and the resident had diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery with Other Forms of Angina Pectoris, Type 2 Diabetes Mellitus with Hyperglycemia, Dementia in Other Diseases Classified Elsewhere, Severe, with Other Behavioral Disturbance, Alzheimer's Disease with Late Onset, and Chronic Obstructive Pulmonary Disease, Unspecified. Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) 12/5/25 for Resident #68 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. Record review of the Quarterly Wander Evaluation dated 12/6/2025 revealed Resident #68 was a wander/elopement risk. During an interview on 12/15/25 at 11:30 AM Licensed Nursing Home Administrator (LNHA) described her understanding of the incident involving Resident #68. She stated she first became aware of the elopement when the Business Office Manager (BOM) came into their staff meeting to alert them that Resident #68 was inside the pharmacy across the street from the facility. She said this occurred at 2:53 PM on 12/10/25. She stated that Social Services, Activities Director, and the Director of Nursing immediately left the facility to go across the street to the pharmacy. She stated that at 2:55 PM, Social Services, Activities Director, and the Director of Nursing walked into the pharmacy where Resident #68 was observed standing, laughing and conversing with the pharmacy staff. She confirmed that Resident #68 was returned to the facility at 3:00 PM. During an interview on 12/16/25 at 10:54 AM, Pharmacy Technician stated she works at the pharmacy across the street from the facility. She reported that between approximately 2:30 PM and 3:00 PM she had just delivered medications to the facility. She stated that she entered the facility through a side door that was unlocked. After she dropped off the medications, she was sitting in her car in the parking lot when a male individual flagged her down and walked up to her car window. She stated the individual asked if she could give him a ride to (proper name of a nearby town), stating he was a good person, loved the Lord, and only needed to be dropped off at the city limits. She stated			F0689			

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F0689 SS = SQC-J	Continued from page 9 he told her his name and offered her \$350 to provide the ride. She reported she declined his offer and drove away. She further stated that after leaving the facility parking lot, she realized the individual was a resident of the facility and remembered his name as that of a resident that she had just delivered medications for to the facility. She contacted her boss at the pharmacy, who instructed her to return to the facility and let the staff know about the possible elopement. While she was in route back to the facility and on the phone with her boss, she was informed that the resident had just walked into the pharmacy. Additionally, she stated she turned around and went back to the facility and told them that the resident had been in the parking lot when she was outside and he was now across the street inside the pharmacy. During an interview on 12/16/25 at 11:12 AM, Licensed Practical Nurse (LPN) #1 revealed that she worked at the front nursing station on the day of the elopement. She reported that the resident repeatedly attempted to go to the exit door and stated that he needed to go home to his wife. LPN #1 stated that she placed a chair at the nursing station and had the resident sit beside her. She reported that Resident #68, for the most part, remained seated at the nurses' station. She offered him magazines to look at and allowed him to watch videos on her phone. She stated that she conducted visual checks at least every hour. LPN #1 stated that the resident was already listed in the facility's elopement book as being at risk for elopement. She confirmed that she had no idea how the resident had gotten through the locked door and got outside of the building and stated, "We think he probably walked out with a visitor." She reported that the facility currently has five residents on elopement precautions. She stated that she maintained her own visual list of the resident's location, checking his whereabouts every 30 minutes to one hour. LPN #1 reported that when the resident returned following the elopement, he was confused and restless, and the facility initiated one-to-one observation. She stated that after the elopement incident, the facility provided education to staff regarding elopement precautions. LPN #1 stated that her shift was from 6:00 AM to 6:00 PM. She reported that at 6:00 PM, the night shift nurse assumed care of the resident, and the resident remained on one-to-one observation. During an interview on 12/16/25 at 11:20 AM, Certified Nursing Assistants (CNA) #1 and #2 both stated that although they do usually work the hall where Resident #68 resides, they were interviewed regarding training implemented after the elopement incident. They both			F0689			

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F0689 SS = SQC-J	Continued from page 10 confirmed that Resident #68 was anxious and exit seeking prior to his elopement. Both CNAs stated that they were off duty on the day of the elopement. CNAs #1 and #2 stated that since the elopement, the facility had implemented new training and protocols for residents at risk of elopement. They reported that CNAs are required to document every 30 minutes for residents identified as being at risk for elopement and listed in the facility's elopement book. They stated that documentation is completed every 30 minutes in the computer charting system. During an interview on 12/16/25 at 11:24 AM, the Director of Nursing (DON) stated that she knew the resident prior to admission and reported that she did not anticipate the elopement. She stated, "I've known him for a long time prior to this," and reported that she did not recall any prior wandering behavior. The DON stated that during a staff meeting, the BOM notified staff that the resident had eloped and was located at the drugstore across the street from the facility. She reported that the drugstore staff, that made a delivery to the facility, first noticed the resident outside of the facility. The DON stated that a staff member from the drugstore returned inside the facility and notified staff. The DON stated that she, along with the Activities Director and the Social Worker, got into a car and went across the street to retrieve the resident. She reported that when they arrived, the resident appeared happy to see them and did not appear distressed or aware that he had done anything wrong. She stated that the resident told her he was trying to get to where his wife was, and she stated that I told him that his wife was coming to the facility and he returned to the facility without difficulty. The DON stated that the resident was wearing lace-up tennis shoes, pants, and a long-sleeved shirt. She reported that the weather was cool but not frigid. The DON further stated that once the facility became aware of the elopement, staff immediately checked all doors and windows and completed a headcount of all residents. She reported that after the resident returned to the facility, staff completed a body audit to ensure he was not injured. She stated that the facility contacted a local business to install a keypad on the front door. The DON reported that the facility conducted in-service education on elopement and abuse. She stated that once the issue was identified, the resident was placed on one-to-one observation, with one staff member assigned to continuously monitor the resident to prevent further elopement. During an interview on 12/16/25 at 11:34 AM, Social Services (SS) #1 reported that prior to the elopement,			F0689			

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F0689 SS = SQC-J	Continued from page 11 she had not observed exit-seeking behaviors for this resident. She stated that on the day of the elopement, she observed the resident standing in a resident's doorway at approximately 2:39 PM while she was walking to a meeting. SS #1 stated that once staff were notified of the elopement, she and other staff immediately got into a vehicle and went to the drugstore across the street to retrieve the resident. She reported that the resident appeared happy to see staff. She stated that the resident may have made a comment at the drugstore about needing to get to his wife. SS #1 stated that after the resident returned to the facility, several interventions were implemented. She reported that the facility had installed a new lock on the front door. She stated that going forward, the front door must be physically opened by staff using a keypad code. She reported that after 5:00 PM, the facility limits access to one entrance only, and individuals must be buzzed out by staff. SS #1 stated that family members were notified of these changes, including the limitation to one entrance after 5:00 PM and on weekends, to more closely monitor all comings and goings. SS #1 stated that when the resident first arrived at the facility, he was constantly pacing, but she believed he had calmed down somewhat since admission. She reported that on the day of the elopement, the resident was dressed in street clothes and was wearing a jacket. She stated that the jacket covered his identification bracelet, and she could see how a visitor might mistake him for another visitor rather than a resident. SS #1 stated that she believed the resident may have exited the building behind a visitor. She reported that on the first night of his admission, the resident paced throughout the facility and was unable to remain still. She stated that staff had CNAs follow behind him throughout that first night. SS #1 stated that when the drugstore clerk first observed the resident, he was standing on the sidewalk and had not traveled far from the facility before staff became aware of his location. During an interview on 12/16/25 at 11:41 AM, LPN #2 stated that she was working at the back nursing station on the same hall as the resident on the day of the elopement. She reported that she had been talking with the resident about his past work as a game warden and stated that the resident engaged in conversations with different people. She reported that the resident was trying to find his house and talking about how he needed to get home and check on his wife. LPN #2 stated, "I don't know how he got out. Maybe someone was coming in and he slipped out." She further stated that nurses document on residents identified as wanderers every hour. She reported that nursing documentation		F0689				

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F0689 SS = SQC-J	Continued from page 12 includes the resident's location and behaviors and that this hourly documentation was already in place at the time of the elopement. She stated that the change implemented after the elopement was that CNAs are now required to document every 30 minutes. She reported that CNAs document every 30 minutes, while nurses continue to document hourly on the resident's behaviors and location. On 12/15/25 at 2:30 PM observed that the facility front lobby is a separate area from where the resident rooms are and the residents reside. There is a set of double doors with a coded, locked entrance to enter the area where the resident rooms are found. Prior to this incident on 12/10/25 the front lobby area was unsecured, and the multiple entrance and exits were unlocked and unsecured. Observation on 12/15/25 at 2:35 PM revealed that the exits and entrances in the front lobby are coded and locked now and you must have a code to leave the building or be let into the building. Observation revealed the distance from the facility to the pharmacy, where the resident was found, was approximately one hundred yards. The pharmacy is located across the street from the facility, and the resident would have crossed a busy two-lane street with no cross walks with speed limits of 35 miles per hour to have reached the pharmacy parking lot. Record review of the local weather history according to Custom Weather, Inc., for the facility for 2:53 PM on 12/10/25 revealed the temperature was fifty-seven (57) degrees Fahrenheit, passing clouds with zero (0) precipitation, eighteen (18) mile per hour winds. Corrective Action Plan On 12/15/25 at 3:30 PM the State Agency presented an Immediate Jeopardy templet which notified the Administrator of the facility that the facility failed to ensure Resident #68, who has a BIMS score of 3 (cognitively impaired) was adequately supervised to prevent elopement. On 12/10/25 at 2:53 PM it was reported to administrator that Resident #68 was noted in the drug store located across from the facility, asking for a ride to see his wife. Staff members assisted residents safely back inside the facility. Decision was made to report and start investigation. Notifications: Son Responsible Party notified by phone on 12/10/25 at			F0689			

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F0689 SS = SQC-J	Continued from page 13 3:23 PM Medical Director notified 12/10/25 with no new orders State Department of Health notified on 12/10/25 at 5:28 PM Regional Director of Operations/Regional Nurse Consultant 12/10/25 per phone Director of Nursing, Assistant Director of Nursing, Social Services, notified 12/10/25 in person Ombudsman notified 12/10/25 per phone Police Department 12/10/25 at 3:40 PM Immediate Actions: 1. Body Audit: with no negative findings performed on 12/10/25 2. Resident #68 placed on 1:1 on 12/10/25 3. 100% head count of residents on 12/10/25 4. Door codes changed at all entrances 12/10/25 by maintenance director. 5. Education of all staff started on 12/10/25 on wandering/elopement and completed 12/10/25. No staff will be allowed to work until in-services are complete. 6. Education to all staff on not providing the code to anyone other than staff. Education began on 12/10/25 and was completed on the same day by the Director of Nursing. 7. Magnetic lock doors activated at front lobby entrance doors on 12/10/25. 8. 100% audit of elopement books completed, noted that these were up to date and updated 12/10/25 by Social Services director. No negative findings were noted with this audit. 9. All residents in the Elopement book were placed on 1-hour visual checks per nursing and 30-minute visual checks per Certified Nursing Assistants on 12/10/25. 10. Elopement drill completed on 12/11/25 by maintenance director.			F0689			

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F0689 SS = SQC-J	Continued from page 14 11. Emergency Quality Assurance and Performance Improvement meeting with Medical Director and Interdisciplinary team on 12/11/25. 12. 100% psychosocial orders put into place for all residents on 12/10/25. 13. Wandering/elopement evaluation form completed for 100% of all residents on 12/11/25. 14. All families were notified of the new entrance process into the facility on 12/11/25. 15. Checked all doors and windows on 12/10/25 by the Maintenance Director. Continued Monitoring: 1. Code W drills will be done weekly x (times) 4 weeks then monthly and as needed (PRN) starting on 12/11/25. 2. Newly hired staff will be trained on the wandering/elopement prevention plan starting on 12/11/25. 3. Residents will be assessed for elopement risk on admission, quarterly, and with any significant changes starting on 12/11/25. 4. Resident continues 1-hour visual checks per nursing and is now placed on 30-minute visual checks for Certified Nursing Assistants (CNA)s starting 12/10/25. 5. Social Services to audit the elopement/wander book weekly x 4 weeks, then biweekly x 4 weeks, then monthly thereafter starting 12/10/25. 6. Minimum Data Set Nurse to audit wander/elopement care plans weekly x 4 weeks, then biweekly x 4 weeks starting 12/10/25. Timeline: At 2:45 PM LPN was doing rounds and visualized resident speaking to another resident on nursing station 1 hallway while she was sitting in her doorway. Resident #68 was dressed in pants, a long sleeve jacket, and lace up shoes. The nurse continued to make rounds while the residents visited with one another. Numerous staff members wrote statements of visualizing the resident on the hall around the same time frame.			F0689			

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F0689 SS = SQC-J	Continued from page 15 At 2:50 PM Pharmacy Tech with local pharmacy arrived at the facility and came inside to deliver meds. At 2:53 PM The Business office manager came into our staff meeting to alert us that Resident #68 was inside the pharmacy. At 2:55 PM Social Services, Activities Director, and the Director of Nursing walked into the pharmacy where the Resident #68 was observed standing, laughing and conversing with the pharmacy staff. At 2:57 PM Resident #68 willingly came with us back to the facility. At 3:00 PM Resident #68 was back and safely inside the facility. Facility alleged that all corrective actions were implemented on 12/11/25 and the Immediate Jeopardy removed on 12/12/25. On 12/15/25, the SA validations were made onsite during the complaint investigation through interviews, observations and record reviews that all corrective actions had been taken by the facility to remove the IJ and the IJ was removed on 12/12/25, prior to the SA entrance on 12/15/25.		F0689				
F0851 SS = F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the		F0851				

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F0851 SS = F	Continued from page 16 long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. 4th Quarter 2025. Findings Include:		F0851				

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F0851 SS = F	Continued from page 17 Record review of the facility policy titled, "Staffing Hours-Monitoring of Policy and Procedure "undated, revealed, "Purpose: To assure the facility staffing meet federal and state guidelines." Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2025 (July 1-September 30)", revealed the facility triggered on this report for excessively low weekend staffing.During an interview on 12/17/2025 at 3:20 PM, the Administrator revealed that after auditing the low weekend staffing data, she discovered that the data submitted to PBJ was inaccurate. She revealed that both she and the Director of Nurses (DON) had worked some weekends, and their salary hours were not accurately converted to hourly. The Administrator also revealed that, after further investigation into the excessively low weekend staffing, it was discovered that there was a data entry error with their vendor Paylocity, which failed to capture all employees who worked during the time period in question.		F0851				