STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Manor Care Center	821 US Hwy 81 W New Braunfels, TX 78130

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property was provided for 1 of 9 residents (Resident #9) reviewed for misappropriation and exploitation, in that: The facility did not prevent Resident #9's personal belongings from being lost when he discharged to the hospital. This failure could affect residents and their responsible party by preventing them from having access to their personal effects and belongings. The findings included: Record review of Resident #9's face sheet, dated [DATE], revealed the resident was admitted on [DATE] with diagnoses that included: dementia, anxiety, and mood disorder. The resident was a male age 79. The RP was listed as a family member. Record review of Resident #9's quarterly MDS, dated [DATE], revealed the resident had BIMS score of 01 (severe cognitive impairment). Record review of facility's discharge list, dated [DATE], revealed Resident #9 expired in the facility on [DATE] under hospice care. Record review of Resident #9's Nurse Note dated [DATE] authored by LVN M reflected: Progress Note: Resident was pronounced dead at: [DATE] 10:46 PM. Further review revealed Resident #9's RP was notified of the resident's death. The resident's personal effects were documented as, none, and not sent to the RP or the Mortuary. Also, the said note reflected, No, Personal effects secured for release at a later time . During a telephone interview on [DATE] at 1:50 p.m., Resident #9's RP stated the facility, never returned [to her the resident's] property after his death . Resident #9's RP stated she remembered the resident's belongings included six different blankets and all the resident's clothes. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with LVN M on [DATE] at 2:28 p.m., LVN M stated no inventory was done on Resident #9's belongings at admissions or at discharge. LVN M stated, no personal effects, belonging to Resident #9 were returned to the family or the RP. LVN M stated the admitting nurse and the discharge nurse were responsible for inventorying the resident's personal belongings. During an interview with the DON on [DATE] at 3:15 p.m., the DON stated at admission a nursing staff member inventoried what personal items the resident brought into the facility. The DON stated the procedure for Resident #9 was to do a paper inventory; but as of [DATE] the inventory was not done or located in the EMR. The DON stated when new items were brought into the facility, the inventory sheet was supposed to be updated and signed by nursing staff. The DON stated at discharge the personal items were supposed to be inventoried by a nursing staff and the items are to be given to the resident or the RP. Regarding Resident #9, the DON stated, signatures are not captured and noted in the progress notes; in other words, no inventory of Resident #9's personal belongings was done by nursing staff either at admission or discharge. The DON repeated the facility could not find an inventory sheet involving Resident #9 done at admissions or discharge. Record review of facility's Transfer or Discharge Documentation dated revised [DATE] reflected, .When a resident is transferred or discharged from the facility, the following information will be documented in the medical record .Disposition of personal effects. Record review of the facility's Admitting the Resident: Role of the Nursing Assistant policy dated revised February 2022 read, .Assist with Inventory of the Resident's Personal Effects . Record review of facility's Resident Rights policy dated revised February 2021 reflected, .be free from abuse, neglect, misappropriation of property . Record review of the facility's Abuse, Neglect, and Exploitation dated revised [DATE] read, The facility will provide protection for health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Review of the facility's electronic forms did not reveal the presence of any electronic form addressing inventory of personal belongings at admissions or discharge of a resident.

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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 - 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** 34957 Based on observations, interviews, and record reviews the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for 2 of 8 residents (Residents #1 and #2) reviewed for accidents hazards and supervision, in that: 1. On [DATE] at 8:54 a.m., Resident #1 was found outside the facility near a busy two way street near the facility. The facility did not investigate whether Resident #1 had received adequate supervision. Also, the facility did not have a mechanism in place for monitoring the front door to ensure resident supervision/monitoring resulting in Resident #1's elopement. 2. On [DATE] at 6:45 a.m., Resident #2 was found bleeding from the head from an unwitnessed fall in the Women's Secured Unit. Facility staff were not monitoring the resident's movements and were aware the resident was agitated. Facility's failure to provide adequate supervision resulted in the resident suffering a large subdural hematoma from a fall from a rolling stool in the dining room. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 6:35 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility needed to establish a permanent alarm system for the monitoring of the front door. The failure could place residents at risk of experiencing accidents, injuries, and/or death. The findings included: 1. Record review of Resident#1's face sheet, dated [DATE] revealed, the resident was admitted on [DATE] with diagnoses that included: dementia, major depressive disorder, and anxiety. Resident was a male age 62. The RP was listed as a family member. Record review of Resident#1's quarterly MDS, dated [DATE], revealed: o BIMS Score was 5 (,d+[DATE]: severe cognitive impairment.) ADLs for transfer was supervision only. ROM listed no impairments. Record review of Resident #1's Care Plan dated [DATE], revealed the goals and interventions included: placement in the secured unit due to wandering and/or exit seeking behaviors. An approach documented in the said CP was for Frequent staff rounding and redirection when wandering/exit seeking observed. Record review of Resident#1's MAR (medication administration record), dated [DATE] revealed, Psychotropic medications included: Aricept 5 mg 1 tab daily (dementia) and Zoloft 25 mgs I tab daily (depression) and Depakote 125 mgs 1 tab twice per day (dementia). (continued on next page)

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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 - Few	Record review of Resident#1's Skin Assessments revealed : (dated [DATE]) revealed: skin intact. Record review of Resident #1's Fall Risk Score (dated [DATE]) revealed, a rating of not at risk for elopement. Record review of Resident#1's Physician' Orders, dated [DATE] , revealed no specific order for the close monitoring of the resident. Record review of Resident #1's Nurse Notes revealed: [DATE] at 8:59 a.m., authored by LVN A revealed: the LVN was notified the resident had left the Men's Secured Unit. LVN A and CNA B went outside the facility and saw Resident #1 walking down the street. A visiting family member offered LVN A car transportation to bring Resident #1 back to the facility. The MD and RP were notified of the elopement. LVN A conducted a full assessment of the resident and no injuries found. [DATE] at 9:07 a.m. authored by LVN A revealed: Resident #1 put on 15 minute checks for elopement prevention. Record review or staff statements date [DATE] revealed: CNA B documented : staff became aware of resident missing between the hours of 8:00 am to 9:00 am. CNA B assisted LVN A in returning the resident back to the facility. Housekeeping Aide C documented she was in the front room and saw resident leaving to the front door and notified HR Aide D [no time listed]. HR Aide D reflected: at 8:56 am ([DATE]) she spoke to Housekeeping Aide C and was informed the resident [Resident #1] left through the front door; and notified LVN A. Record review of facility's internal investigation packet revealed: 5 day investigation report was completed and the finding was missing person confirmed. In-service on the topics of abuse and neglect and elopement were initiated on [DATE]. 72 hour monitoring sheet was present. During a telephone interview on [DATE] at 9:45 AM, a message was left for return call to surveyor. Called returned at 10:00 AM. Housekeeping Aide C stated that she saw Resident #1 leaving the facility and did not follow him or maintain eye contact. Housekeeping Aide C stated she informed HR Aide D about Resident #1 leaving through the front door. During an observation and interview on [DATE] at 9:00 a.m., Receptionist E stated in the month of February 2024 she was made receptionist for the front desk [day shift] with the duty to observe residents and visitor movements at the front door. Observation revealed that there was no bell or alarm on the front door that alerted staff when a person entered or left through the front door. Receptionist E stated the door was not monitored on weekends/nights or when she left the front desk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on [DATE] at 10:30 a.m., revealed during while the path Resident #1 took when he was found to be a missing person on [DATE] was walked, with the Administrator, the resident had walked outside the facility's boundary for about 100 feet before being found at a local charity store. There was a busy street with traffic in both directions in the path the resident took on [DATE], and the Administrator stated the resident did not cross the busy street but continued to walk on the sidewalks parallel to the nursing facility. The Administrator stated, fortunately a family member and the former MDS Nurse saw the resident walking down the sidewalk while driving in their respective cars and immediately notified the facility of the resident walking away from the facility. The Administrator stated the facility when notified of the missing person dispatched nursing staff to convince the resident to return to the facility; the resident returned and was placed back in the Men's Secured Unit. The Administrator stated the preventative measures put in place after the incident on [DATE] included: in-service training on abuse/ neglect and missing persons, signs of the doors on the secured units advising all staff and visitors to use the door and check for piggy-backing (residents following visitors or staff), change of door codes, and verification of the census. Observation on [DATE] on [DATE] at 10:35 a.m. of Men's Secured Unit revealed there were two signs inside the unit which read: Stop .Please ask for assistance from staff when entering and exiting a secure unit . Please do not let unsupervised residents leave the secured unit unattended. The signs to the entrance of the Men's Secured Unit read: Please ask for assistance from staff when entering and exiting a secure unit. During an observation and interview on [DATE] at 11:34 a.m., Resident #1 was in bed in the Men's Secured Unit, alert and oriented to person and place; cleaned and groomed. The resident did not reveal signs of injury, bruises or skin tears, and the resident was ambulatory. The resident stated: I did leave .but do not remember .not sure whether someone saw me leaving .I walked alone when the door opened .no one stopped me .I was going to my house .I did not want to be here .they found me and brought me back .I probably was gone for five minutes .I feel safe here .but I want to be in my house .I have not tried to escape again .if taken to my house I will stay in my house .the door is now locked in the [unit] and I cannot leave .I have not tried to leave again .there is no abuse .no neglect .I just want to be home . During an interview with the Administrator and MDS Nurse G on [DATE] at 11:53 a.m., the Administrator and MDS Nurse G revealed the following timeline involving the missing person incident on [DATE]: 8:55 a.m.: from Nurse progress note authored by LVN A stated Resident #1 had completed eating breakfast and likely followed a visiting person outside the Men's Unit. 8:55 -8:56 a.m.: Housekeeping Aide C was sitting up front (from interview with the Administrator) and she saw the resident leaving the front door and reported to HR Aide D. [no process/procedure or elopement training was in place at the time of the incident] 8:56 a.m.: (from written statement authored by HR Aide D) statement made that HR Aide D called the Men's Unit and notified the nurse station and spoke to LVN A. 8:56 a.m.: (from interview with Administrator) a visitor and the MDS Nurse H (no longer an employee) alerted someone in the facility that the resident was seen away from the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8:56 a.m.: LVN A and CNA B (no longer an employee) left the facility immediately to retrieve the resident. 8:57 a.m.: LVN A and CNA B met up with the resident about ,d+[DATE] feet and convinced the resident to return (in nurse notes) and accepted a visitor's offer to drive the resident and staff back to the facility. 8:59 a.m.: Nurse Note authored by LVN A stated that resident was back in the secured unit. During an interview with MDS Nurse G on [DATE] at 2:10 p.m., MDS Nurse G stated after the elopement of Resident #1 the 72-hour monitoring order was discontinued on [DATE]. MDS Nurse G stated the resident did not experience any other exit seeking behaviors after [DATE]. MDS Nurse G stated law enforcement was not notified; but the MD, and RP were notified of the elopement. During an interview with HR Aide D on [DATE] at 2:48 p.m., HR Aide D stated the statement written on [DATE] was correct. HR Aide D stated she did not maintain eye contact of Resident #1 because she was not sure the person identified by Housekeeping Aide C was a resident of the facility. HR Aide D stated after the training on missing persons the highlight was to follow the person until help arrived. During an interview with the ADON on [DATE] at 6:01 p.m , the ADON stated she was told by LVN A that Resident #1 had left the Men's Unit on [DATE]. The ADON stated the code to the Secured Men's Unit might have been given to a regular family member not related to Resident #1 who visited the Men's Unit and the resident had followed someone's family member on the day of the incident. The ADON stated the current practice was for only paid staff to have the secure units' codes and to educate agency nursing staff not to give the code out. The ADON stated, in-service was given and the codes were changed and a door bell was placed in the secured units to announce entering the secured units after the incident. Record review of facility's Emergency Procedure-Missing Resident dated revised [DATE] read, .Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety . Record review of the facility's Wandering and Elopements policy dated revised [DATE] read, .Adequate supervision will be provided to help prevent accidents or elopements . 2. Record review of Resident #2's face sheet, dated [DATE] revealed, the resident was admitted on [DATE] with diagnoses that included: dementia, osteoarthritis (weak bones), and agitation and restlessness. Resident was a female age 84. RP was listed as a family member. Record review of Resident#2's Care Plan revealed the goals and interventions included: [start date [DATE]] at risk for falls with interventions: assistance, re-direction, safety measures, and monitoring. [[DATE]] additional interventions: proper foot attire, and keep pathway free of obstacles. Record review of Resident #2's quarterly MDS dated ,d+[DATE] revealed: BIMS score was 99 (unable to answer questions), transfer was listed as supervision, bed Mobility was listed as supervision, and ROM was documented as no impairments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's Fall Risk Score (dated [DATE]) revealed a rating of high risk for falls. Record review of Resident #2's Nurse Note authored by LVN K, dated [DATE], revealed, resident did not sleep well and was agitated all night. At 6:15 a.m. the resident was in the dining area near the trash can and pick-up the trash can and carried it around. The resident was re-directed and sent to her room. Resident returned to dining room and LVN K and CNA J heard and noise and noted resident on the floor lying next to a rolling stool on her right side and blood was noted on the floor. Resident was bleeding from the forehead and pressure was applied to the site. Vitals taken (temp 98.0 (normal), pulse 54 (normal), respiration 18 (normal), Blood Pressure ,d+[DATE] (normal), O2 (95% room air-normal). 911 was called. LVN K notified Hospice, RP, and MD of the unwitnessed fall. Record review of Resident #2's clinical record revealed, Resident #2 was found on the dining room floor bleeding from the head from an unwitnessed fall on [DATE] at 6:45 AM. Staff members in the Women's Secured Unit were not monitoring the resident's movement in the dining room after the resident displayed agitation and left obstacles in her pathway. Resident #2 was taken by EMS to a local hospital where she was assessed and eventually underwent surgery for a large subdural hematoma with mid line shift (bleeding in the brain creating pressure on one side of the brain). Hospital status post finding revealed a craniotomy (a surgical procedure to remove the subdural hematoma) on [DATE]. Record review of Resident #2's hospital record dated [DATE] revealed: resident had a large subdural hematoma with mid line shift; placement in ICU; and physical restraint for aggression and behaviors. Status post craniotomy (a surgical procedure to remove the subdural hematoma) on [DATE]. Resident was discharged to another NF on [DATE]. Hospital diagnoses at discharge: SDH and Alzheimer's disease, HTN and history of falls. Record review of facility's discharge list dated [DATE] revealed Resident #2 was discharged [DATE] to hospital and did not return. Record review of Resident #2's Skin Assessments revealed: (dated [DATE]) laceration to the upper right side of the forehead; no measurements. Record review of Resident #2's Fall Risk Score (dated [DATE]) revealed, a rating of high risk for falls. Record review of Resident #2's Physician' Orders, dated [DATE] revealed, no specific order for more than routine monitoring the resident's movements in the secured unit. Record review of Resident #2's incident report dated [DATE] authored LVN K revealed: unwitnessed fall with injury from fall in dining room involving a rolling stool. Record review of facility's Provider Investigation Report dated [DATE] involving the incident on [DATE] revealed: Disciplinary action taken against CNA J, LVN K and NA L; all three employees were terminated. Rolling stools removed from the Unit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Investigation summary: Overall, the allegations did not prove [Resident #2] had an unwitnessed fall with significant injury. [Resident #2] had a laceration to the right side of forehead and was admitted to hospital with a diagnosis of brain bleed (some old and some new) .disciplinary action taken .rolling stools removed . education provided . 5 day report submitted; finding was inconclusive. Start of neuro checks pending EMS arrival from 6:45 AM-7:15 AM. Inservice on fall prevention [DATE] for 35 employees in the secured units. Record review of three terminated employees' written statements revealed: LVN K [hire date [DATE]]: at [DATE] at 6:45 a.m. when resident fell the LVN [K] was standing in front of the nurse's cart away from the resident. CNA J [hire date [DATE]]: not present in the dining room when fall occurred; location was at hall near Nurse station. CNA L [hire date [DATE]]: not present when fall occurred; location was at the Nurse Station. Record review of three terminated employee files revealed: they had received Abuse/Neglect Training and Fall Prevention Training at hiring and also on the day of the incident [DATE]. Record review of facility's employee list of dated [DATE] revealed: 13 dedicated staff assigned to the secured units. Record review of in-service training on fall prevention started [DATE] to [DATE] revealed 117 employees received the training (100 % completion rate). Record review of the facility's Wandering and Elopements policy, dated revised [DATE], read, .Adequate supervision will be provided to help prevent accidents or elopements . Record review of facility's Resident Rights policy, dated revised February 2021, read, .rights include the resident's right to .a dignified existence .be free from abuse, neglect, misappropriation of property, and exploitation . Record review of facility's Falls-Clinical Protocol policy, dated Revised [DATE], read, .The physician will help identify individuals with a history of falls and risk factors for falling .The staff and practitioner will review each resident's risk factors for falling and document in the medical record . During an interview on [DATE] at 11:58 a.m., NP stated she was informed of the unwitnessed fall involving Resident #2 from a rolling stool. The NP stated there were no orders other than routine monitoring of residents in the secured unit. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on [DATE] at 12:36 p.m., the Administrator stated his investigation revealed the unwitnessed fall was actually witnessed by the staff hearing the fall. The Administrator stated he terminated all the 3 employees (CNA J, LVN K and NA L) because thy failed to monitor the dining room before breakfast meal which led to Resident #2 falling from a rolling stool. The Administrator stated post incident the interventions put in place included: no rolling stools in the secured unit, an in-service of staff, fall risk assessments for secured unit residents, and updated care plans if necessary. The Administrator stated the timeline of the incident on [DATE] was: unwitnessed fall at 6:45 a.m. EMS arrived at 7:15 a.m.

During telephone call on [DATE] at 2:13 p.m., Hospice RN stated: hospice was contacted concerning the resident falling in dining room and suffering a laceration to the head requiring a visit to the ER.

During a telephone interview on [DATE] at 2:21 p.m., the RP stated , .[the resident] was sent to the ER and had to undergo brain surgery .she was hospitalized for one week and put in ICU for the brain bleed .after the hospital stay [Resident #2] was transfer to another NF for three months and then died .I hold [the NF] responsible for the death of [Resident #2]. The RP stated that she was notified of the incident on [DATE].

In interviews on [DATE] from 10:00 a.m. to 10:30 a.m. with 5 day shift (6:00 a.m. to 6:00 p.m.) nursing staff (1 LVNs and 3 CNAs) and one other (Activity Tech) in the Men's Secured Unit; also, in the Women's Unit nursing staff (1 LVN and 2 CNAs); revealed: they had been in-serviced on fall prevention in the Secured Units with the highlights of: no rolling stools, no objects that could create hazards or accidents, no wet floors and maintaining supervision of the residents. Further interviews of 5 night staff (6:00 p.m. to 6:00 a.m.) (2 LVNs, 2 CNAs, and 1 MA) revealed they had the latter fall prevention training on maintaining safety in the secured units as well as throughout the facility.

In interviews on [DATE] from 12:15 p.m. to 12:30 p.m. 15 with day shift (6:00 a.m. to 6:00 p.m.) nursing staff (1 LVN and 1 CNA), 9 therapy staff (day shift) (4 PTAs, 3 OTs, 1 SP, 1 Rehab Tech) and 3 night shift (6:00 p.m. to 6:00 a.m.) included (1 LVN and 1 MA) and 9 other staff (1 Maintenance, 2 HR, and 1 Housekeeping) staff nursing and; further interviews of 5 night staff (6:00 p.m. to 6:00 a.m.) (2 LVNs, 2 CNAs, and 1 MA) revealed they had been in-serviced on fall prevention in the Secured Units with the highlights of: no rolling stools, no objects that could create hazards or accidents, no wet floors and maintaining supervision of the residents; also no fall or accident hazards throughout the facility.

The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: [DATE])

1. 100 percent completion rate for in-service of 117 paid staff on fall prevention (completed [DATE]).

2. Immediate Inservice on fall prevention on [DATE] for 35 employees assigned to the secured units.

3. Termination of the three employees (LVN K, CNA J, and NA L) for failing to provide supervision to Resident #2.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Assessment of resident #2 at time of fall and transferring the resident to the ER. 5. Neurology checks before the arrival of EMS from 6:45 a.m. to 7:15 a.m. 6. Assessing the scene of the fall and removing rolling stools. 7. Notifying the RP, Hospice, and MD of the fall. Observation of Women's and Men's Secured Units on [DATE] and [DATE] revealed no rolling stools present or equipment or objects that could create accidents and hazards and adequate supervision. During telephone interview on [DATE] at 4:10 p.m., LVN K stated the resident was agitated and moving in and out of resident rooms and eventually found a trash can she carried. LVN K stated the resident was redirected and sent back into her room in preparation for the breakfast meal. LVN K stated the resident was left unsupervised and returned to the dining hall where she found a rolling stool and tried to sit on it a fell . LVN K stated at the time of the incident she was preparing medications for morning dispensing. LVN K stated she was terminated because Resident #2 was left unsupervised. During a telephone interview on [DATE] at 4:51 p.m., CNA J stated that Resident #2 was highly agitated on [DATE] and wandered throughout the unit and eventually found a rolling stool where she fell from. At the time of the incident, CNA J stated she was at the nurse station doing documentation. CNA J stated she was terminated for not monitoring Resident #2 on the day of the fall. Attempted telephone calls to [DATE] at 3:55 p.m. and 4:00 p.m. to NA L revealed the phone was busy not accepting any calls or messages. Interviews with 33 day and night staff (8 LVNs, 9 CNAs, 3 MAs, 9 Rehab staff, 1 Housekeeping, 1 HR, 1 Maintenance, and 1 Activity) on [DATE] from 1:00 p.m. to 2:00 p.m. revealed they had received an in-service on fall prevention with the return demonstration highlights: check on obstacles in the secured units and throughout the facility that could create accidents and hazards. The Administrator was notified of an Immediate Jeopardy (IJ) on [DATE] at 6:35 p.m. The Administrator was provided with the IJ Template and a Plan of Removal was requested. The facility provided a Plan of Removal which reads as follows: Plan of Removal: 689: Accidents, Hazards, Supervision & Devices Date Initiated: [DATE] Today's Date: [DATE] The facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 22 residents (Resident #1) reviewed for adequate supervision. All residents residing on the secured unit can be affected by this deficient practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2024
NAME OF PROVIDER OR SUPPLIER: Colonial Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 821 US Hwy 81 W New Braunfels, TX 78130	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Action Performed: Action: Resident #1 was assisted back into the nursing home, resident was assessed, elopement assessment performed, and care plan updated. Resident was placed on 15 min checks until evaluated by the Psychology provider and medication review and adjustments completed. Notified the Administrator, Notified MD, and Responsible Party. Person(s) Responsible: Director of Nursing Date: [DATE] Action: - Resident head count performed with all residents residing at [the facility]. No other missing residents identified. - Elopement assessment performed on all residents at [the facility]. Any residents residing on the secured unit have elopement assessment, secured unit assessment, orders, consent and care plans in place. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: [DATE] Action: To prevent future occurrence the facility has- Placed signs on the inside and outside of the secured unit doors informing staff, vendors, and visitors to Please do not allow residents to follow you out. Secured unit doors codes have been changed, staff aware of the codes, doorbell installed and visitors/vendors will be let in by staff. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: [DATE] Steps to Achieve Compliance: Action: Resident #1 was assessed for and further exit seeking behaviors and elopement risk assessment performed. They resident care plan was updated. Person(s) Responsible: Director of Nursing Date: [DATE] (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Place a staff member, continuously on all shifts at the front door until the Interdisciplinary Team (Including minimum Administrator, Director of Nursing, Assistant Director of Nursing, and Maintenance Director) can implement an alarm or a keypad that would alarm and/or require a code to exit the front door of the center. Person(s) Responsible: Administrator, Maintenance Director, and/or Designee Date: [DATE] Action: Elopement assessments reperformed on all residents. Elopement assessments and Secure Unit assessments will be repeated quarterly, annually and with significant change. The DON will review elopement assessments weekly to ensure they are completed timely. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: [DATE] Action: Missing Resident & Wandering/Elopement education provided to all staff to include: If you note a resident (with emphasis a resident on the secured unit) attempting to exit any door, stay with resident and ensure that they have signed out and/or have appropriate supervision. Elopement book has been verified as updated and staff education on location of the elopement book, which includes residents on the secured unit that are at risk for elopement. The Elopement Book will be updated daily with any changes by the Social Worker/designee. All employees, including new and temporary, to be educated prior to working their next shift. All newly hired employees will be education during orientation, prior to first scheduled shift The DON/designee will review the next days schedule daily to ensure that any staff scheduled to work on the oncoming shifts have been educated. Person(s) Responsible: Administrator, Director of Nursing, and/or Designee Date: [DATE] Action: Ad hoc QAPI performed with Medical Director to inform of the Immediate Jeopardy template and the facility's action to remove the immediacy. Person(s) Responsible: Administrator Date: [DATE] Verification of Plan of Removal: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on [DATE] at 10:30 a.m. the front door was locked and when opened by the Admissions Coordinator, a bell sounded. Observation further revealed that a reception desk was set up with a ledger near the entrance to control traffic and out of the facility. The Admissions stated that her assignment was to monitor traffic during her shift. She stated that the facility was working on a permanent alarm system for the front. Observation on [DATE] at 11:26 a.m. of Resident #1 revealed the resident was in the secured men's unit in the dining room socializing with other residents. Observation on [DATE] at 12:05 p.m. of Men's Secured Unit had two signs inside the unit that read: Stop . Please ask for assistance from staff when entering and exiting a secure unit .Please do not let unsupervised residents leave the secured unit unattended. The signs to the entrance of the Men's Secured Unit read: Please ask for assistance from staff when entering and exiting a secure unit. The Women's Secured Unit signs read: Please do not allow residents to follow you out .Ensure door is locked behind you . Observation also revealed that the doorbell are operating in both secured units. Observation on [DATE] from 2:45 p.m.-2:55 p.m. revealed the location of the elopement books at: station 1, station 2, Men's Secured Unit and the Women's Secured Unit. Record review of Resident's Nursing note dated [DATE] at 8:59 a.m. authored by, LVN A revealed the resident eloped from the facility and was missing for about 5 minutes; was assessed and returned to the facility. Record review of Resident #1's elopement evaluation on [DATE] revealed high risk for elopement. Record review of Resident #1's CP dated [DATE] revealed: the resident was an elopement risk. Record review of Resident #1's behavior monitoring dated [DATE] to [DATE] revealed monitoring done and completed; see attachment. Record review of Resident #1's Psychology evaluation on [DATE] by [psychiatric company] revealed: medications reviewed and follow-up visits. Record review of Resident #1's Medication review done by the NP dated [DATE] revealed: medications reviewed and new order for Aricept 5 mgs once per day at bedtime (dementia). Record review of Resident #1's Nurse Progress note dated [DATE] authored by LVN A revealed the MD was notified and the RP. Record review of facility's census audit on [DATE] revealed 124 residents were present and no other resident had eloped. Record review of sample residents (Residents #3 through #7) revealed elopement assessment was completed on [DATE]. Record review of Secured Units' census on [DATE] revealed: Men's was 34 and Women was 22. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of sample residents in the Men's Unit on [DATE] revealed Resident's clinical record contained the elopement assessment, secured unit assessment, orders, consent and care plan was in place. Record review of sample residents in the Women's Unit on [DATE] revealed Resident #8's clinical record contained the elopement assessment, secured unit assessment, orders, consent and care plan was in place. Record review of Resident #1's elopement assessment dated [DATE] authored by RN revealed the assessment was present; and resident assessed for high risk of elopement. Record review of Resident #1's CP dated [DATE] revealed: the CP was updated and to closely monitor the resident for wandering and elopement. Record review of facility's POR binder revealed 117 elopement assessments were present. Record review of training on Missing Residents for 117 staff members revealed: 117 signatures were present for 100% completion. Record review or email dated [DATE] to Medical Director revealed a discussion on the IJ and the POR. During an interview on [DATE] at 12:09 p.m. the DON stated the codes to the locked units had been changed and would be changed every three months unless compromised. The DON stated, Staff were made aware of the codes individually when she made rounds and during orientation. The DON stated that the codes are not given to agency staff or visitors. During an interview on [DATE] at 12:43 p.m., the Corporate Nurse stated that corporate headquarters is exploring a permanent solution for the front door monitoring to prevent elopement and tracking visitors. During an interview on [DATE] at 12:49 p.m., the DON stated, yes .117 elopement assessments were completed .the resident at risk for elopement resided in the secured units was a total of 51 residents .the scale for elopement was 'at risk' and 'not at risk' . In interviews on [DATE] from 1:00 p.m. with 10 day shift (6:00 a.m. to 6:00 p.m.) nursing staff (2 LVNs, 4 CNAs, 1 MAs) and 3 other staff (SW, admissions, and HR); and 10 night shift (6 p.m. to 6 a.m.) nursing staff (3 LVNs, 4 CNAs) and 3 Other