STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455550	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Nursing & Rehabilitation	280 Moffitt Dr Center, TX 75935

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49017 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment that did not result in bodily injury were reported to the state agency within 24 hours for 1 of 7 residents (Resident #1) reviewed for abuse and neglect. The Administrator failed to report to the state agency withing 24 hours concerning an allegation of neglect on 07/23/2024 when Resident #1 eloped from the secured unit out of the entrance doors to the unit and out of the front entrance of the facility. This failure could place residents at risk for harm and injury. Findings include: Record review of an Admission Record dated 3/25/2025 for Resident #1 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia with behavioral disturbances (A group of symptoms that affects memory, thinking and interferes with daily life), Post Traumatic Stress Disorder (a mental health condition that's caused by an extremely stressful or terrifying event), psychosis (a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not), and Alzheimer's Disease(a neurodegenerative disease that usually starts slowly and progressively worsens). Record review of a Brief Interview for Mental Status (BIMS) assessment for Resident #1, dated 7/25/24, indicated severe cognitive impairment with a score of 5. Record review of baseline care plan dated 7/22/2024 indicated that Resident #1 was cognitively impaired and was at risk for elopement. Record review of hospital's physician progress note dated 7/17/24 indicated that the resident required a secure nursing facility placement related to his wandering behaviors and elopement risk. Record review of one-on-one observation sheets for Resident #1 revealed the one-on-one started on 7/23/24 at 10:30 AM and were initiated by the ADON. One on one observations continued until 7/25/24 at 4:45 PM when the resident was transferred to a behavioral health hospital. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Social Worker on 3/25/25 at 2:00 PM, she indicated there was an incident of a missing resident occurring in 2024. She was not able to recall the exact date. She said a resident from the secured unit was reported missing and she was able to recall assisting staff in looking for the resident in the facility. She stated the resident was located across the highway and was not injured. She said the resident was transferred to a behavioral health hospital shortly after the incident. She was not certain if the incident was reported. She stated the administrator was responsible for reporting incidents. During an interview with the ADON on 3/26/25 at 11:15 AM, she stated one on one observations were initiated related to Resident #1's elopement from the facility. She said on 7/23/24, LVN A asked her if she had seen Resident #1 and she could not locate him in the secured unit. She said all staff were alerted and began looking for Resident #1. She said shortly after starting the search, Resident #1 was found by another staff member across the highway in the shopping center parking lot. She said Resident #1 was assessed with no injuries noted. She said one on one monitoring was initiated. She stated she notified the physician of the incident. She stated the Administrator notified the responsible party. The ADON did not complete an incident report. She stated the administrator was responsible for reporting incidents to the state agency. During an interview with the Administrator on 3/26/25 at 11:26 AM, he was able to recall an elopement incident that involved Resident #1 that occurred 07/23/24. He said it was reported that Resident #1 was missing from the secured unit and that the facility's missing resident protocol was initiated. He said Resident #1 was located within 10 minutes. He said the resident was found by staff across the highway and was escorted back to the facility without incident. He stated he did not report the incident due to the resident being found quickly and without injury. Record review of a nurse progress notes for Resident #1 dated 7/23/24 to 7/25/24 showed no documentation of the elopement that occurred on 07/23/2024. Record review of facility incident reports for July 2024. There were no completed incident reports for Resident #1. During an interview with the DON on 3/25/25 at 2:15 PM, she stated she had no knowledge of the incident because she was on approved leave during that time. Record review of a facility policy titled Elopement effective 12/2018 indicated, The following steps are to be followed when a resident is noted absent and is not found on initial search of home. This also includes when a resident leaves the home grounds without staff notification. Administrative staff will: Determine if elopement is reportable to state regulatory agency. Record review of a facility policy titled Abuse/Reportable Event no dated printed on policy, indicated, The facility administrator or designee will report the allegation to HHSC . If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. The policy defined an adverse event as untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof.

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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** 49017 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents. The facility failed to prevent Resident #1 from eloping on 7/23/2024 when he was able to exit the secured unit and exited the facility through the main entrance. The noncompliance was determined to be PNC (past non-compliance) . The IJ (Immediate Jeopardy) began on 7/23/24 and ended on 7/23/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for serious injury and accidents. Findings include: Record review of an Admission Record dated 3/25/2025 for Resident #1 reflected he admitted to the facility on [DATE] and was [AGE] years old with diagnosis of dementia with behavioral disturbances (A group of symptoms that affects memory, thinking and interferes with daily life), Post Traumatic Stress Disorder (a mental health condition that's caused by an extremely stressful or terrifying event), psychosis (a collection of symptoms that happen when a person has trouble telling the difference between what's real and what's not), and Alzheimer's Disease (a neurodegenerative disease that usually starts slowly and progressively worsens). Record review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE] reflected the Resident #1 had severe cognitive impairment with a score of 5. Record review of the baseline care plan dated 7/22/2024 reflected that Resident #1 was cognitively impaired and was at risk for elopement. Record review of a hospital Physician's Progress Note dated 7/17/24 reflected Resident #1 required a secure nursing facility placement related to his wandering behaviors and elopement risk. During an interview on 03/25/2025 at 1:30 PM, LVN A, who was the nurse on duty at the time of Resident #1's elopement, said she could not recall an elopement occurring in the last 12 months. During an interview with the Social Worker on 3/25/25 at 2:00 PM, she indicated there was an incident of a missing resident occurring in 2024. She was not able to recall the exact date. She said a resident from the secured unit was reported missing and she was able to recall assisting in looking for the resident in the facility. She stated the resident was located across the highway and was not injured. She said the resident was transferred to a behavioral health hospital shortly after the incident. (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	During an interview with LVN B on 3/25/25 at 3:30 PM, she stated she recalled an elopement incident occurring with a resident last year. She stated that the resident no longer resided in the facility. She stated she was not working at the time of the incident therefore she did not know the details. During an interview with CNA C on 3/25/25 at 3:45 PM she stated that she recalled an elopement incident that occurred within the last 12 months. She could not remember any details. She stated she was not working at the time of the incident, but recalled the incident being discussed. During an interview with the Maintenance Supervisor on 3/25/25 at 4:00 PM, he was able to recall an elopement incident that involved Resident #1 during his stay. He stated he was unsure how the resident was able to exit the building. He stated the resident was located across the highway at the shopping center's parking lot. He stated at the time of the incident, all doors were secured and locking mechanisms were functioning properly. He denied any failures to the keypad systems required to open doors at the main entrance and the secured unit . During a telephone interview with Resident #1's responsible party on 3/26/25 at 8:45 AM she stated Resident #1 was admitted to the facility for a short period of time July 2024. She stated she received a telephone call from the facility second day the resident was at the facility in reference to Resident #1 leaving the facility unattended. She stated the facility reported that Resident #1 had exited the facility and was found across the highway at the shopping center's parking lot. She said the resident did not suffer any injuries as a result of the incident. She stated the facility reported that visitors opened the doors that allowed the resident to exit the facility. She stated Resident #1 was transferred to a behavioral health hospital shortly after the incident related to his aggressive behaviors. During an interview on 3/25/25 at 3:15 PM, the ADON said that she initiated the one-on-one monitoring for Resident #1 on 7/23/24 related to his aggressive behaviors and exit seeking. She said the resident had torn down curtains and was exhibiting aggressive behaviors on 7/23/24. She stated the resident was placed on continuous monitoring to ensure the safety of the resident as well as the other residents located in the secured unit . During an interview with the Administrator ADM on 3/25/25 at 1:00 PM he stated he was not able to recall any elopement incident occurring in the last 12 months. During a follow up interview, with ADON on 3/26/25 at 11:15 AM, she stated one on one observations were initiated related to Resident #1's elopement from the facility. She said on 7/23/24, LVN A asked her if she had seen Resident #1 and that she could not locate him in the secured unit. She said all staff were alerted and began looking for Resident #1. She said shortly after starting the search, Resident #1 was found by another staff member across the highway in the shopping center parking lot. She said Resident #1 was assessed, with no injuries noted. She said one on one monitoring was initiated. She stated she notified the physician of the incident. She stated the Administrator notified the responsible party. The ADON was not able to provide an explanation as to why an incident report was not completed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow up interview on 3/26/25 at 11:26 AM, the Administrator stated he was able to recall an elopement incident that occurred 7/23/24 with Resident #1. He said it was reported that Resident #1 was missing from the secured unit and the facility's missing resident protocol was initiated. He said Resident #1 was located within 10 minutes. He said the resident was found by staff across the highway and was escorted back to the facility without incident. During the interview, the Administrator presented a file containing in-services, written statements, and the resident elopement assessments completed on the date of the incident. During a follow up interview with LVN A on 3/26/25 at 1:00 PM she confirmed she was the nurse on duty on 7/23/24. She stated she could not recall an elopement incident with Resident #1. A written statement by LVN A written on 7/23/24 provided to her for review and she was unable to provide any details of the incident. During an observation performed 3/25/25 between 9:30 AM and 10:00 AM and 3/26/25 between 2:00 PM and 2:20 PM of the secured unit access door revealed visitors were unable to access the area from the main building unless a large red button located on the adjoining wall was pushed. A sign above the door reflected for anyone entering to not allow anyone out of the area and to ensure the door had shut after entering. Observation of the door from the secured unit to outdoor patio area revealed it required a 4 digit code to access the outside area and to enter from the outside back into the secured unit. Observation of the gate located in outdoor secured area revealed it required a 4 digit code to open to the parking area. A code was also required to enter the patio area from the parking lot. A 4 digit code was required to exit the secured unit to the main hallway. The doors or gate could not be opened without a code. Observation of the outdoor patio area revealed no loose or broken fencing noted. Observation of the main lobby area revealed the door was secured and unable to enter or exit building without a 4 digit code. Outside of the building was a doorbell used by visitors and staff entered a code to the door to allow entrance. A sign was observed at the entrance that reflected visitors not allow residents outside without notifying staff. During an observation performed on 3/25/25 10:00 AM of the windows located in secured unit revealed no cracked or broken glass to any windows. Windows were secured and closed. to the [NAME] were unable to be raised to a height that would allow a person to exit the room. During an observation performed on 3/25/25 at 12:00 PM of the facility entrance to the location that Resident #1 was found indicated that the resident had to walk across a 2 lane highway and approximately 100 yards to the parking lot of the shopping center. Review of the local weather conditions according to the National Weather Service on 7/23/24 reflected that the recorded high temperature was 94 degrees Fahrenheit and the recorded low temperature was 76 degrees Fahrenheit. Record review of the facility incident reports for July 2024 revealed there were no completed incident reports for Resident #1. Record review of Resident #1's progress notes dated 7/22/24 to 7/25/24 revealed the resident's length of stay, and did not reflect any elopement incident. (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 one-on-one observation sheets for Resident #1 revealed the one-on-one started on 7/23/24 at 10:30 AM and were initiated by the ADON. One on one observations continued until 7/25/24 at 4:45 PM, when the resident was transferred to a behavioral health hospital. Record review of the Administrator's investigation file dated 7/23/2024 indicated an in service titled Resident Safety/ Elopement was performed for all staff on 7/23/24. The resident elopement/wandering risk assessments were performed on all residents. Written statements by the ADON, LVN A, CNA D and ADM dated 7/23/24 were contained in the file. Record review of written statement dated 7/23/24 at 10:00 AM written by the Administrator revealed Resident #1 was not in the building and a search was initiated. Resident#1 was found and returned to the building with no injury assessed. Staff education was initiated, and the resident was placed on one-on-one supervision. The statement indicated resident was out of the building for approximately 10 minutes. Record review of written statement dated 7/23/24 at 10:00 AM written by the ADON indicated LVN A approached the ADON and stated she could not find Resident #1. The ADON stated all staff were notified and a search for the resident was started. The ADON's statement reflected all doors and windows were checked for signs of exit. The statement reflected the resident was confused and agitated when he returned to the building. A head-to-toe assessment was performed by LVN A with no injuries noted. Record review of a statement by LVN A dated 7/23/24 indicated LVN A observed the resident walking up the hallway toward the front. The statement reflected no other details were provided. Record review of a statement by CNA D dated 7/23/24 indicated CNA D observed Resident #1 ambulating up hallway towards front. The statement reflected no other details were provided. The facility took the following actions to correct the noncompliance on 7/23/24: Record review of the documentation provided by the Administrator indicated in-services were conducted on 7/23/24 with all staff on resident safety and elopement. During an interview on 3/26/25 at 8:45 AM with Resident #1's responsible party, she indicated she was notified of the incident on 7/23/24. Record review of a progress note dated 7/23/24 indicated Resident #1's physician was notified and an order for behavioral health evaluation was obtained. Record review of the elopement/wandering assessments revealed assessments were performed on all residents in the facility on 7/23/2024. Record review of one-on-one observation for Resident #1 revealed the observations were started 7/23/24 at 10:30 AM and ended on 7/25/2024 at 4:45 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 3/25/25 and 3/26/25 with 3 CNAs, 4 LVNs, 2 housekeeping staff and 1 dietary staff on day and evening shifts revealed the employees indicated they would report a missing resident to administrative staff. All staff indicated a search of the facility and grounds was to be performed and that law enforcement was to be contacted if a resident not located within 30 minutes. All staff indicated Code Orange was communicated to alert all facility personnel of a missing resident. All staff reported doors were to remain closed and secure. Staff reported door codes were not shared with residents or visitors. Record review of facility policy titled Abuse/ Reportable Events reflected It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect .and situations that may constitute abuse or neglect to any resident in the facility. The noncompliance was determined to be PNC (past non-compliance) . The IJ (Immediate Jeopardy) began on 7/23/24 and ended on 7/23/24. The facility had corrected the noncompliance before the survey began.