STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455560	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Nursing Center	600 N Cynthia St McAllen, TX 78501

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 5 residents (R #1) reviewed for care plans. The facility failed to ensure R #1's care plan reflected the use of the wander guard, the antibiotics R #1 received for ESBL (bacterial infection) in the urine, and falls he experienced on 07/01/24, 07/10/24 and 07/14/24. This failure could place residents at risk of not receiving the care and services as indicated in the comprehensive care plans. The findings included: Record review of R #1's face sheet dated 07/24/24 reflected an [AGE] year-old male, with an original admitted [DATE]. Diagnoses included type 2 diabetes, hepatic encephalopathy (brain dysfunction caused by liver dysfunction), mood disorder, unspecified psychosis, hypertension, dementia with other behavioral disturbance, alcohol abuse (in remission), muscle weakness, lack of coordination, and cognitive communication deficit. Record review of R #1's Minimum Data Set (MDS) assessment dated [DATE] reflected R #1 had a BIMS score of 8 (moderate cognitive impairment) and required supervision (oversight, encouragement, or cueing) for bed mobility and transfers. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R #1's incident reports dated 07/01/24, 07/10/14, and 07/14/24 reflected the fall protocol was followed and interventions were implemented for each fall. On 07/01/24 at 5:35 AM, as per 1:1, R #1 rolled out of bed, hitting head on bedside dresser, causing laceration/abrasion to upper forehead. R #1 was assessed and his vitals within normal limits. R #1 noted with continued aggressive behavior. MD ordered for R #1 to be sent to the hospital. RP notified. Hospital contacted and report was given. R #1 was transferred to the hospital at 5:40 AM. Resulted in no other injury besides abrasion to right side of forehead. Recommendations from the team: wound care for abrasion, rehab screen, re-educate to use call light for assistance, neuro checks, and send to hospital for evaluation. MD and RP notified. On 07/10/24 at 7:00 PM, nurse rounding noted R #1 laying on his right side next to his bed, awake, and able to respond. Head to toe assessment completed with no complaints of pain. Staff assisted R #1 and R #1 was in good spirits and joked. As per family members, R #1 was sitting himself down on the side of the bed, misjudged his placement and slid down to the floor/onto his right side. No injuries observed. MD was notified, RP at bedside aware, started neuro checks as per facility protocol, call light within reach, and bed to lowest position. Recommendations from the team: rehab screen, re-education on call light, fall prevention protocol and therapy, and therapy targeted strength, bed mobility, and walking. On 07/14/24 at 2:38 AM, staff reported to nurse that they found R #1 on the floor. Nurse assessed R #1 and R #1 was laying down on his left side with head above the floor. It appeared that R #1 slid off his chair in attempting to get up from chair. R #1 stated he was trying to go back to bed. R #1 denied pain or discomfort. No injuries observed. Reported fall to NP and was instructed to complete neuro checks. Fall precautions continued to be in place. Informed R #1 to use call light for assistance. Bed was at the lowest position and call light within reach. DON and RP notified. Recommendations from the team: rehab screen, re-educate on call light, neuro checks and rehab addressed safety awareness, transfers, gait, and balance. Record review of R #1's order summary dated 07/24/24 reflected the wander guard was initiated for R #1 on 05/24/24: wander guard on at all times for elopement prevention, licensed nurse to assess wander guard every shift to assure it is working properly every shift. Order summary reflected the order for the IV antibiotics: Use 1 gram every 12 hours for bacterial infection/ESBL to the urine until 07/14/24 with start date of 07/04/24. Record review of R #1's MAR dated 05/24/24-07/25/24 reflected a licensed nurse checked the wander guard every shift to assure it was working properly. MAR reflected R #1 received the antibiotics for ESBL in the urine as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R #1's Care Plan dated 07/24/24 reflected R #1 was at risk of Wandering/Exit Seeking: Resident wanders related to cognitive impairment and is at risk for injury related to: Mood Disorder due to known physiological condition. Date Initiated: 05/24/24. Attempt to determine any pattern or cause of wandering, reassure resident when distressed over placement, mark room door with a familiar object, photo, etc. to aid in remembering room location as indicated, redirect if resident enters a restricted area, notify the immediate supervisor if unable to locate the resident, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, etc. Date Initiated: 05/24/24. R #1's care plan reflected the elopement. Additional interventions after elopement: will find a secured unit for resident to transfer to upon acceptance, will place on one to one and place window alarm as soon as available, and window alarm placed on 07/19/24. Date Initiated: 07/19/24. R #1's care plan reflected R #1 had the potential for falls related to. Date Initiated: 05/24/24. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs, encourage socialization and activity attendance as tolerated, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, fall risk screening upon admission and quarterly to identify risk factors, place the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 05/24/24. Velcro shoes will be used instead of lace shoes. Date Initiated: 07/25/24. -R #1's care plan did not reflect the wander guard R #1 had placed since 05/24/24. R #1's care plan did not reflect the IV antibiotics R #1 received for ESBL to the urine from 07/04/24-07/14/24. R #1's care plan also did not reflect the falls R #1 experienced on 07/01/24, 07/10/24, and 07/14/24 or the interventions implemented for each fall. Interview with LVN A on 07/24/24 at 5:25 PM revealed LVN A said R #1 had been on IV antibiotics for ESBL to the urine about a week before R #1 eloped. Interview with RN A on 07/25/24 at 2:05 PM revealed RN A said R #1 had the wander guard in place and the nurses ensured he wore the wander guard and that it functioned properly. RN A said R #1 was on IV antibiotics for ESBL to the urine when he returned from the hospital on 07/04/24. RN A said she assisted LVN A for one of the falls R #1 experienced on 07/10/24. RN A said R #1's FM was in the room, and he was not injured. RN A said the fall protocol was followed and they continued to monitor him. RN A said they did implement different interventions for each fall, depending on the cause of the fall. RN A said the administration or the doctor, collaborated to try to implement something, but she was unsure of what was implemented for this fall. Interview with LVN A on 07/25/24 at 3:30 PM revealed LVN A said R #1 had been on IV antibiotics for ESBL to the urine. LVN A said R #1 finished the antibiotics on 07/14/24. LVN A said she worked with R #1 when he fell on [DATE]. LVN A said she was in the hall and heard a noise come from R #1's room. LVN A said she went to the room and checked on him. LVN A said R #1's FMs were in the room with him. LVN A said the FMs said that R #1 did not fall but slid off the bed when he went to sit down on the bed. LVN A said she assisted R #1 back into bed and assessed him. LVN A said R #1 had no injuries, but she followed the fall protocol and monitored him. LVN A said she completed the incident report which was part of the protocol. LVN A said R #1 wore the wander guard even before the incident of elopement and continued to have it in place. LVN A said it was part of the MAR to ensure R #1 was wearing the wander guard. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LVN C on 07/25/24 at 4:30 PM revealed LVN C said he worked on 07/01/24 when R #1 had a change of condition as he fell /rolled out of bed. LVN C said it happened during the overnight shift at around 5-5:30 AM. LVN C said R #1 was on a 1:1 and had his bed low. LVN C said he did not recall which staff was assigned to him. LVN C said R #1 rolled out of the bed as he reached for some beans or some food he had on the dresser. LVN C said R #1 turned, rolled off the bed, and hit his head on the dresser next to his bed. LVN C said the 1:1 staff notified LVN C as he called out for help. LVN C said he assessed R #1 and assisted him back up. LVN C said R #1 had a small cut on his eyebrow, approximately 1 centimeter in size. LVN C said he applied pressure to the cut as it was bleeding minimally. LVN C said he notified the doctor and the doctor decided to send him out to the hospital as a precaution. LVN C said he also notified R #1's FM. LVN C said R #1 returned from the hospital and his tests were negative for head injury or other injury. LVN C said the small cut had been scabbed over and it did not require stitches or further medical attention. LVN C said he followed the protocol for the incident and completed the incident report. LVN C said R #1 returned from the hospital with orders for IV antibiotics for ESBL to the urine. LVN C said the orders were carried out. LVN C said R #1 had the wander guard in place because he tried to exit seek since he was admitted . LVN C said the nurses checked the wander guard every day on every shift to ensure R #1 had it on and it was working. Interview with LVN D/MDS Nurse on 07/25/24 at 5:15 PM revealed LVN D said the comprehensive care plan was broken down by departments and each department would add information as needed such add changes or implemented interventions. LVN D said the team discussed any changes or incidents during the morning meetings and throughout that day, the departments went in and adjusted the care plan as needed. LVN D said R #1 had the wander guard since he was admitted , start date on 05/24/24, but she did not know why the care plan did not reflect the wander guard. LVN D said there was a different MDS Nurse back then. LVN D said the wander guard was definitely something that should have been care planned. LVN D said even though it was not in the care plan, the nurses checked the wander guard every day on every shift. LVN D said she updated the care plan for R #1 today, 07/25/24, to reflect the wander guard. LVN D said for falls, the ADON updated the care plans as that was considered risk management and the ADON took care of those. LVN D said the ADON would also have care planned the interventions for the elopement, but she knew they implemented the window alarm, the 1:1, and to find him a secured unit. Interview with RN G on 07/26/24 at 10:10 AM revealed RN G said R #1 had received IV antibiotics therapy when he came back from the hospital for ESBL to the urine and he was on isolation precautions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON on 07/26/24 at 10:45 AM revealed the ADON said the MDS nurse was the staff that updated the care plans. The ADON said for R #1 and the other residents that had the wander guard, the wander guard was something that should have been care planned. The ADON said the MDS nurse was relatively new to the role. The ADON said R #1 was admitted in May 2024 and the other MDS Nurse that left would have been the one to ensure the wander guard was care planned. The ADON said he was unsure how often they reviewed the care plans, but they had meetings for the care plans. The ADON said they had a morning meeting and went over falls, change of conditions, any discharges, etc. The ADON said each department was in the morning meetings. The ADON said if there were falls, those were care planned or should have been care planned. The ADON said on 07/01/24, R #1 rolled off the bed and the interventions implemented were a rehab screen, re-educated to use the call light, neuro checks and he had a little scrape on top of his eyebrow, so they did wound care. The ADON said the cut/scrape R #1 was not a serious injury. The ADON said for the second fall, on 07/10/24, they did a rehab screen, re-educated to use the call light for assistance, therapy targeted upper body strength, bed mobility and walking. The ADON said those were the interventions implemented for that fall. The ADON said R #1's FMs were there when that fall happened, and R #1 was not injured. The ADON said R #1 sat on the bed and slid down. The ADON said it was witnessed and not a true fall, but more like he slid down. The ADON said on 07/14/24, R #1 was going back to his bed, laid down and slid off the bed. The ADON said R #1 was not injured. The ADON the interventions implemented were a rehab screen, re-educated on call light, neuro checks, and therapy addressed safety awareness, gait and balance. The ADON said for each fall they always completed rehab screen. The ADON said he filled out the paperwork for the incident reports and discussed it in the meetings if they needed further interventions. The ADON said the team usually followed the rehab recommendations. The ADON said for falls sometimes they added a visual aide, maybe changed in the room, or adjusted the wheelchair if the resident used one. The ADON said the interventions implemented would have been added to the care plans. The ADON said the interventions were not inputted into R #1's care plan for each fall. The ADON said he was not sure if they needed to update the care plan for each fall. The ADON said they usually had a meeting with himself, MDS nurse, and the DON for care plans. The ADON said he was not sure exactly who was responsible for the care plan being updated. The ADON said there were interventions for each incident for R #1. The ADON said R #1 was also on IV antibiotics when he came back from the hospital on 07/04/24. The ADON said the antibiotics were for ESBL to the urine. The ADON said the IV antibiotics should have also been care planned but it would come off the care plan once R #1 finished the antibiotics. The ADON said he was not sure if those antibiotics were care planned. The ADON said the importance of care planning different things was so that staff knew R #1's behaviors, knew how to care for him, and knew about him. The ADON said the care plans were individualized to each resident and it was important to keep the care plans updated and accurate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 07/26/24 at 11:40 AM revealed the DON said she worked at the facility for about a month and R #1 wore the wander guard already when she began. The DON said R #1 was on a 1:1 but then R #1 was sent to the hospital on 07/01/24 because he had a fall and had a small laceration to the eyebrow. The DON said the fall protocol was followed and he returned on 07/04/24. The DON said R #1 did not have an order for a 1:1 when he returned. The DON said R #1's cut was scabbed and treated by wound care. The DON said R #1 also returned with orders for IV antibiotics for ESBL to the urine and the isolation precautions. The DON said the orders were followed and carried out. The DON said R #1 had other falls on 07/10/24 and 07/14/24 which resulted without injury. The DON said the fall protocol was followed for those incidents and there were no concerns. The DON said there were interventions implemented for each fall on 07/01/24, 07/10/24 and 07/14/24. The DON said it was important for the care plans to be updated so staff knew how to care for the residents. The DON said antibiotics should have been care planned and it did not matter if it was through IV or oral. The DON said the wander guard should have been care planned. The DON said falls should have been care planned. The DON said if those things were not care planned, how were staff supposed to know. The DON said as far she knew the orders were still followed and interventions were implemented, but the care plan was not updated for R #1. The DON said she was already formulating her plan of correction and started providing training and re-education to staff. The DON said she did not know what happened before she arrived and started working at the facility, but she was going to try to fix the issues. Interview with the ADM on 07/26/24 at 1:40 PM revealed the ADM said R #1 had 3 falls this month, July 2024. The ADM said the fall protocol was followed for those falls. The ADM said everything was done appropriately and followed up on for the falls. The ADM said the staff notified the nurse, the nurse assessed, called the doctor, obtained/carried out orders, and notified the family. The ADM said there were no serious injuries that resulted from the falls and there was nothing that was reportable. The ADM said the care plan policy said for them to do an incident report for each fall and it said on the incident report what the interventions were. The ADM said she did not think that the care plan needed to reflect each fall. The ADM said she would review the policy and ensure they followed what they needed to do. The ADM said the DON had only worked here for about 4 weeks, so they were still adjusting, reviewing, and learning. The ADM said the DON was also implementing new information and ideas. The ADM said reviewed the care plan for R #1 and the care plan did not reflect the IV antibiotics, falls for July 2024, or the wander guard. The ADM said the current care plan reflected the wander guard but that was updated on 07/25/24, after the state entered. Record review of Fall Management System Policy Origination date: 09/01. Review date: 02/19/21. Revision date: 01/03/17. Policy: It is the policy of this facility that each resident will be assessed to determine his/her risk for falls, and a plan of care implemented based on the resident's assessed needs. A. 3. A care plan is implanted for residents at risk for falls. D. 1. A licensed nurse will complete an incident/accident report after each fall. D. 4. Documentation in the nurse's notes and/or care plan will reflect interventions attempted. D. 8. An administrative nurse will ensure that the resident's' care plan is revised to reflect each fall and interventions that were implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Comprehensive Care Plans Date implemented: 02/10/21. Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 3. The comprehensive care plan will describe at a minimum: a. The services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being. 6. Alternative interventions will be documented, as needed.

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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** 47573 Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 5 residents (R #1) reviewed for supervision. The facility failed to ensure R #1 received adequate supervision as R #1 eloped from the facility without anyone's knowledge on 07/19/24 between 7:30-7:40 PM and was found at an apartment complex approximately 0.2 mile away. R #1 was exit seeking, had increased behaviors, and staff placed R #1 in his room and failed to request additional interventions or increased supervision. R #1 was out of the facility for approximately 30 minutes before the facility became aware that he had eloped. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 07/19/24 and ended on 07/22/24. The facility corrected the non-compliance before the investigation began. This failure could lead to residents exiting the facility unattended which could result in injuries, hospitalization , or death. The findings included: Record review of R #1's face sheet dated 07/24/24 reflected an [AGE] year-old male, with an original admitted [DATE]. His diagnoses included type 2 diabetes, hepatic encephalopathy (brain dysfunction caused by liver dysfunction), mood disorder, unspecified psychosis, hypertension, dementia with other behavioral disturbance, alcohol abuse (in remission), muscle weakness, lack of coordination, and cognitive communication deficit. Record review of R #1's Minimum Data Set (MDS) assessment dated [DATE] reflected R #1 had a BIMS score of 8 (moderate cognitive impairment) and required supervision (oversight, encouragement, or cueing) for bed mobility and transfers. Record review of R #1's elopement assessment dated [DATE] (admission) reflected a score of 11 (a combined score of 6 or more triggered possible elopement risk). At risk to elope and should be placed on the Elopement Risk Protocol. A care plan for Elopement was indicated. (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 R #1's Care Plan dated 07/24/24 reflected R #1 was independent for bed mobility, transfers and ambulation. Date Initiated: 05/24/24. R #1's care plan also reflected R #1 was at risk of Wandering/Exit Seeking: Resident wanders related to cognitive impairment and is at risk for injury related to: Mood Disorder due to known physiological condition. Date Initiated: 05/24/24. Attempt to determine any pattern or cause of wandering, reassure resident when distressed over placement, mark room door with a familiar object, photo, etc. to aid in remembering room location as indicated, redirect if resident enters a restricted area, notify the immediate supervisor if unable to locate the resident, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, etc. Date Initiated: 05/24/24. R #1's care plan reflected the elopement. Additional interventions after elopement: will find a secured unit for resident to transfer to upon acceptance, will place on one to one and place window alarm as soon as available, and window alarm placed on 07/19/24. Date Initiated: 07/19/24. Record review of the Provider Investigation Report dated 07/23/24 reflected an elopement incident involving R #1 on 07/19/24 at 8 PM and was reported on 07/20/24 at 8 PM to the State Survey Agency. Investigation summary : R #1 had a BIMS of 8, diagnosed with diabetes and mood disorder, and had no prior incidents of elopement. Staff were notified by LE that LE had R #1 when LE showed up to the facility with R #1. LVN A called the DON at 8:25 PM that LE had found R #1 at apartment complex nearby. The DON notified the ADM. Staff were immediately redirected and evaluated R #1, assessments completed, wander guard bracelet verified, R #1 on 1:1, risk call and interventions initiated and conducted. Staff interviews conducted revealed LVN A saw R #1 at around 7 PM, when LVN B assisted R #1 to the restroom. At approximately 7:30 PM, R #1 was at the hall door and pressed on the door, the alarm rang, and CNA F and RN G redirected R #1 to his room. RN G administered R #1's medications as ordered. CNA F and RN G placed R #1 in bed with his shoes on per his preference and he wanted his door closed. Staff continued to do their rounds down the hall. LE arrived at the facility with R #1 and LE went to R #1's room, room B-21, with staff. When they entered the room, the window was completely open and the window had not been open earlier. MD and RP were notified. R #1 was placed on a 1:1 at that time. MD orders labs and results were pending. Staff and resident interviews for abuse/neglect conducted. All staff in-serviced. Provider action taken post-investigation: wander guard list validated, wander guard bracelet rechecked, all staff in-serviced, 1:1 continued until placement at secured unit, care plan updated, 1:1 care plan meeting with family, chart review, staff in-serviced for code silver and abuse/neglect, MAR/TAR reviewed, environmental evaluation, incident report completed, post-test follow up audits on code silver will be reported to Quality Assurance for any negative findings, and 100 % of elopement assessments completed for all residents. Findings confirmed. Signed by the ADM on 07/23/24. Description of injury: none. Description of assessment: pain assessment, elopement assessment, head to toe assessment, hydration assessment, glucometer check, vitals checked, and placed on a 1:1 until they got further orders. Provider response: assessments, contacted the ADM/RP/DON, notified the doctor, in-service on elopement and code silver, wander guard bracelet rechecked and in place, binder updated, resident interview, updated care plan, orders for labs, labs taken, and window alarm placed. Attachments included: R #1's face sheet, assessments, notes, labs, order summary, elopement assessments for residents with wander guard, LE report, emergency response drill: missing resident on 07/19/24, worksheets, head count 100 %, elopement assessments completed 100 % from 07/19/24-07/20/24, in-services on elopement, door alarms, elopement drill, wandering residents, head count, code silver, and abuse/neglect, and policies on 07/19/24; doors, locks, gates, alarms and wander guard system checked, and staff post-tests from 07/19/24-07/22/24. (continued on next page)

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McAllen Nursing Center	600 N Cynthia St McAllen, TX 78501

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of R #1's progress notes dated 05/23/24-07/26/24 reflected R #1 continuously attempted to exit seek since his admission on 05/23/24. Staff redirected R #1 and the wander guard was placed on 05/24/24. Staff continued to redirect R #1 as he continued to attempt to exit seek. R #1 was placed on a 1:1 on 05/25/24. Staff continued to exit seek despite of the 1:1 staff and staff redirected R #1. R #1 at times became aggressive or upset due to the redirection as R #1 wanted to leave. Staff explained placement or distracted R #1 with other activities. Staff also reported behaviors to NPs and obtained orders for medications. Staff continuously monitored R #1. Record review of R #1's order summary dated 07/24/24 reflected a wander guard was initiated for R #1 on 05/24/24: wander guard on at all times for elopement prevention, licensed nurse to assess wander guard every shift to assure it is working properly every shift. R #1 was also placed on a 1:1 on 05/25/24 which was discontinued on 07/18/24 at 5:53 PM. R #1 was placed back on a 1:1 on 07/19/24 after the incident of elopement. Record review of R #1's MAR dated 05/24/24-07/25/24 reflected a licensed nurse checked the wander guard every shift to assure it was working properly. Record review of R #1's elopement assessment dated [DATE] (readmission from hospital visit on 07/01/24) reflected score of 4 and still indicated to place him on an elopement risk protocol. Record review of R #1's progress notes reflected: -On 07/18/24 at 12:00 AM, documented by LVN B: R #1 noted with exit seeking behaviors, attempted to open exit door from hall and other doors in the hall. Staff attempted to redirect, and redirection was unsuccessful. As R #1 began to show agitation, the RP was contacted to help speak to R #1 and he was redirected to room. Redirection was unsuccessful. R #1 only complied to sit in a chair by the hallway, voiced he was being kidnapped, and the nurse explained to R #1 that he was in a nursing home due to him needing daily care. R #1 voiced that he did not need care as he cared for himself. R #1 stayed sitting in the chair. Staff continued to monitor. -On 07/19/24 at 7:30 PM, documented by RN G: Was alerted by the hall door alarm. Noted R #1 attempted to exit the facility. R #1 required constant redirection with poor outcome and showed signs of irritability while he was assisted back to his room. Placed R #1 back to bed. All care met and provided for. -On 07/19/24 at 8:55 PM, documented by RN G: Provided skin assessment of R #1. R #1 had clean and intact skin with no scrapes, bruising, or discoloration noted. Skin turgor was normal, skin was cool to touch with normal pigmentation noted. Record review of R #1's SBAR communication form dated 07/19/24 reflected the resident with increased confusion, continues with exit seeking behaviors. Placed on a 1:1. Obtained orders for UA and labs related to increased confusion. Documented by RN G. (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 R #1's elopement assessment dated [DATE] (elopement incident) reflected score of 11 and indicated to place him on an elopement risk protocol. Record review of R #1's progress notes reflected: -On 07/20/24 at 9:12 AM, documented by LVN D: Order given for window alarm. Window alarm placed. RP notified. -On 07/20/24 at 12:27 PM, documented by LVN D: Results received for labs and results relayed to NP. Pending orders. -On 07/20/24 at 2:50 PM, documented by LVN D: New order obtained by the NP for Haldol solution once a day for 14 days. Diagnosis: aggression/behaviors. Nurses to document every shift for 14 days any signs or symptoms of elopement, behaviors, aggression. Nurses to notify NP if behaviors continued. -On 07/20/24 at 2:55 PM, documented by LVN D: Consent obtained by SP to administer Haldol. -On 07/20/24 at 10:44 PM, documented by RN G: R #1 was seen by psych NP. Obtained orders for Haldol for the treatment of psychosis and agitation. Monitor sleep hours and call if condition worsened. Orders placed. Resident rested in bed and on 1:1 supervision for continued exit seeking behavior. -R #1 continued to be monitored by staff. Staff attempted to find placement for R #1 at a secured unit and worked with R #1's RP until placement was found and R #1 was transferred on 07/25/24. Interview with LE on 07/23/24 at 4:45 PM revealed LE was dispatched to an apartment complex nearby the facility. LE said on 07/19/24 at around 7:45 PM she contacted R #1 who was sitting on a bench, sweaty, and thirsty . LE said R #1 was confused and answered her questions with irrelevant answers. LE said R #1 had a phone which she used to call R #1's FM and the FM informed her that R #1 was a resident at the facility. LE said she went to the facility and spoke to the staff. LE said the staff did not know that R #1 was not in the facility. LE said the staff were able to identify R #1 and verified R #1 was a resident. LE said she went to R #1's room with the staff and saw R #1's window was open. LE said her partner brought R #1 to the front of the building and the staff took R #1 back into the facility. LE said R #1 was not injured. LE said the apartment complex where R #1 was found was about a block down the street. Interview with R #1 on 07/24/24 at 2:30 PM revealed R #1 did not answer basic questions appropriately. R #1 answered with irrelevant topics. R #1 appeared confused, stopped answering questions, and did not continue the interview. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation of R #1 on 07/24/24 at 2:35 PM revealed R #1 was in the same room, 21, he was in when he eloped, and staff saw the window fully open on 07/19/24. R #1 was wearing a wander guard on his wrist. Window was observed locked with window alarm. Window was about a foot off the floor and large enough where R #1 had likely fit. Interview with CNA A on 07/24/24 at 3:00 PM revealed CNA A said she worked on the 6 AM-6 PM shift. CNA A said she was informed about R #1's elopement on 07/20/24. CNA A said she was not working at that time. CNA A said she did not work much with R #1 and was not familiar with him. CNA A said she was in-serviced on elopements and abuse/neglect after the incident of R #1 eloping. CNA A said during their rounds they ensured to see each resident and if they noticed someone was missing, she would report it to the nurse immediately, call a code silver, and start looking in all the rooms, restrooms, closets, etc. CNA A said they would search outside and continue to search until the resident was found and if not, then call the police as well. CNA A said she also knew to report any changes to the nurse for any resident. CNA A said she had been in-serviced on these topics before the incident of R #1 eloping . CNA A said there were other residents that wore the wander guard due to exit seeking behaviors or because they wandered, but none of the residents had eloped before as the wander guard and verbal redirection was normally successful. CNA A said she knew to redirect the residents when they tried to go towards the exits. Interview with CNA B on 07/24/24 at 3:55 PM revealed CNA B said she worked on the 6 AM-6 PM shift. CNA B said she worked on 07/19/24 with R #1 during the day and he did not have different behaviors out of the ordinary. CNA B said she worked with R #1 and there were days that he was more confused than others. CNA B said R #1 looked out through the exit door windows, but returned to the hall and did not try to leave. CNA B said R #1 walked slowly, but he walked. CNA B said R #1 wore the wander guard even before the elopement. CNA B said she was informed about R #1's elopement when she worked the next day, 07/20/24. CNA B said that next day, she was in-serviced on what to do when a resident was missing and abuse/neglect. CNA B said they were trained to notify the nurse immediately, call a code silver, and search every room. CNA B said they also did an elopement drill and practiced like if someone was missing. CNA B said she knew to check every resident during her rounds, every 2 hours, and if they were not in their rooms, she would check other areas where they could be. CNA B said she knew to report to the nurse immediately if she noticed any change to the resident such as a change to their skin, change to their health, or changes of behavior. CNA B said she was in-serviced on elopements before the incident happened with R #1. Interview with CNA C on 07/24/24 at 4:15 PM revealed CNA C said she worked 8 AM-5 PM and different hours as needed. CNA C said she supervised the CNAs, completed the schedule, and stocked supplies. CNA C said she worked during the day on 07/19/24 and was gone for the day when R #1 eloped. CNA C said she was informed about the incident the next day, 07/20/24. CNA C said R #1 was known to go towards the doors and was sometimes redirectable, sometimes not. CNA C said R #1 would get upset and would not want to come back away from the doors when being redirected. CNA C said they tried to distract him from going towards the exit doors. CNA C said R #1 had the wander guard in place and the door alarm rang if R #1 got too close to it the door. CNA C said the nurses ensured R #1 had the wander guard in place. CNA C said R #1 was confused at times and was able to walk steadier at times. CNA C said she was in-serviced on elopement and abuse/neglect after the incident of R #1 eloping. CNA C said she also participated in the elopement drills. CNA C said even before the incident, they had provided in-services for elopements and abuse/neglect. CNA C said the CNAs were also aware to report any changes to the nurses right away. CNA C said if the CNAs noticed the resident was acting different, had a new rash, or a new injury, the staff would have reported that to the nurses. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA D on 07/24/24 at 4:40 PM revealed CNA D said she worked on the 6 AM-6 PM shift. CNA D said she did not work when R #1 eloped but was informed about the incident the next day, 07/20/24. CNA D said she had worked with R #1 in the past and knew R #1 could be confused at times and wore the wander guard. CNA D said if R #1 got too close to the doors, the alarms would sound as he wore the wander guard. CNA D said the CNAs and the nurses ensured R #1 had the wander guard on. CNA D said R #1 used the wander guard because he tried to go towards the doors and exit. CNA D said they redirected him and tried to get him to do something else. CNA D said the redirection would usually work but some days were harder than others. CNA D said the staff always monitored R #1 and checked where he was during their rounds. CNA D said the staff rounded every 2 hours and as needed and ensured to see each resident assigned in their hall. CNA D said if the residents were not in their rooms, they checked other areas until they accounted for each resident. CNA D said she was in-serviced on elopements the day after R #1 eloped. CNA D said she was in-serviced on 07/20/24. CNA D said if the staff could not find a resident during their round, they were trained to report it to the nurse, call a code silver, search everywhere inside/outside, and call the police if the resident was not found. CNA D said she was also in-serviced on abuse/neglect. CNA D said they also practiced elopement drills. CNA D said she had been in-serviced on these topics before the incident. Interview with HA A on 07/24/24 at 5:00 PM revealed HA A said she worked on the 6 AM-6 PM shift. HA A said she worked with R #1 on 07/19/24 during the day and was gone by the time R #1 eloped. HA A said she was informed about the incident the following time she worked, but she did not remember the exact date. HA A said R #1 tried to leave in the past and he tried to go exit the doors. HA A said she redirected R #1 constantly as he continued to try to exit seek. HA A said she was informed when R #1 was experiencing a change of condition and knew to report any changes to his behavior. HA A said R #1 exit seeking was not abnormal for him because he would do that all the time. HA A said R #1 knew what he was trying to do when he tried to exit seek and would say to let him go. HA A said she was in-serviced on elopements on 07/22/24. HA A said she was told to notify the nurse if she could not find someone during her rounds, call a code silver, check the rooms, closets, search inside/outside the building, and call the police if the resident was not found. HA A said she was also informed to ensure the residents were not trying leave through the window since R #1 left through the window. HA A said there were alarms installed on the windows so the alarms would sound off too. HA A said she was not sure if the window alarms were placed on all the windows. HA A said R #1 was placed on a 1:1 when he returned and had been on a 1:1 ever since then. HA A said she was assigned to R #1 today and supervised him. HA A said R #1 would remain on the 1:1 until they found another place for him. HA A said she was already trained and in-serviced on elopements even before the incident of R #1 eloping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN A on 07/24/24 at 5:25 PM revealed LVN A said she worked on the 2 PM-10 PM shift. LVN A said she worked on 07/19/24 when R #1 eloped. LVN A said she was in another hall and saw LVN B took R #1 to the restroom at around 7 PM. LVN A said LVN B assisted R #1 in the restroom and then LVN B redirected R #1 back to his hallway. LVN A said RN G was assigned to R #1 that evening. LVN A said she was not sure if R #1 had been exit seeking that day. LVN A said R #1 usually went towards the doors, but the alarms would always sound as he wore the wander guard. LVN A said if they saw R #1 going towards the doors, they redirected R #1 before the alarms went off or tried to. LVN A said she saw R #1 walked towards the end of the halls a couple times. LVN A said she redirected R #1, and he walked back towards the nurse's station and towards his hallway. LVN A said the last time she saw R #1 that evening was when LVN B assisted him to the restroom. LVN A said she saw LE at the front door and let LE in at around 8 PM. LVN A said LE asked if there was a resident missing. LVN A said LE verified it was R #1 that was in their custody. LVN A said she called RN G over since he was assigned to R #1's hallway. LVN A said RN G spoke to LE and LVN A called the DON. LVN A said LE and RN G went to R #1's room and when they opened the door, they saw the window was open. LVN A said LE said her partner would bring R #1 as R #1 had gotten a little aggressive with LE. LVN A said R #1 was sitting outside under the canopy with the other LE. LVN A said RN G ran out with CNA F to get R #1 back inside. LVN A said R #1 was not on a 1:1 before he eloped but was placed on a 1:1 when he returned. LVN A said R #1 was not injured and did not appear dehydrated but looked tired. LVN A said RN G took R #1 to his room and assessed R #1. LVN A said she continued with her rounds in her hallway. LVN A said the DON went to the facility that night and started in-services with all staff. LVN A said she was in-serviced on elopement and abuse/neglect. LVN A said they also completed elopement drills. LVN A said she was trained to call a code silver, staff would respond, assign everyone where to look, search, and notify the DON, ADM, doctor, RP, and LE if needed. LVN A said that protocol was followed for the incident. LVN A said they notified the RP, doctor, DON and ADM. LVN A said R #1 had tried to leave with his family in the past and would say he had to go, or he had to get out of the facility. LVN A said that was normal for him to say and do. LVN A said he wore the wander guard, and they redirected him, distracted him, and tried to offer him different things to keep him safe. LVN A said that was the first time R #1 was able to leave. LVN A said the nurses informed the staff of any changes to the resident and the staff knew to report any changes to the nurses as well. LVN A said she had been in-serviced on elopements before the incident happened with R #1. LVN A said she did not like that this happened to R #1 but sometimes there were not enough staff to monitor everything. LVN A said R #1 had been on a 1:1 since the incident and the residents with the wander guard also had a window alarm installed on their windows for added safety. Interview with SP on 07/24/24 at 7:27 PM revealed SP said she believed R #1 went out the window because R #1 had been saying see that window, I am going to go out that window. SP added that the window was low enough for R #1 to be able to get out. SP did not specify if she informed anyone about R #1's comments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN A on 07/25/24 at 2:05 PM revealed RN A said she worked on the 6 AM-2 PM shift. RN A said she worked with R #1 in the past. RN A said R #1 had exit seeking behaviors since he was admitted and was on a 1:1 since he was admitted . RN A said R #1 was taken off the 1:1 because although he would verbalize that he was going to leave, he was easily redirectable. RN A said she assumed the facility thought R #1 would be fine if he was off the 1:1 but she guessed not since R #1 eloped. RN A said she did not know when exactly R #1 was taken off the 1:1. RN A said she believed it would be administration or the doctor that decided to add or remove the 1:1. RN A said R #1 had the wander guard in place and if he got too close to the doors, the alarms rang. RN A said R #1 usually wanted to call his family member and tried to go towards the doors. RN A said R #1 never mentioned he was going to go out the window. RN A said R #1 would also get aggressive towards staff at times. RN A said she did not work when R #1 eloped but was informed about the incident when she returned to work. RN A said she was provided with the in-service for elopements and abuse/neglect. RN A said even before the recent incident, they had given them in-services for elopements. RN A said they knew what to do in case someone was missing. RN A said during their rounds, they knew to make sure they saw every resident, and if they were not in their room, they looked for them in other areas and made sure they saw them. RN A said R #1 was confused at times. RN A said R #1 asked to speak to his family member, he knew the number by memory, but then he would say that he left his car outside or something that did not make sense. RN A said R #1 had moments of increased confusion but that was not uncommon. RN A said the CNAs knew to report any changes especially if the residents had a UTI. RN A said the CNAs were informed if the resident had a UTI and they knew to report any changes of behavior, or other changes. RN A said R #1 walked slowly. RN A said R #1 did not look very strong but when he had been aggressive, he had a surprising amount of strength. RN A said R #1 would get aggressive both physically and verbally. RN A said she was informed that R #1 was not injured from the elopement. RN A said if R #1 was out in the community, there were apartments around the facility, and if R #1 maybe had spoken to someone the wrong way or gotten aggressive with someone who did not know R #1 was demented or his disease, then she believed R #1 could have gotten hurt in that way. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA E on 07/25/24 at 2:45 PM revealed CNA E said she worked on the 6 AM-6 PM shift. CNA E said she worked with R #1 often but did not work when R #1 eloped. CNA E said before R #1 was sent to the hospital he was on a 1:1 and she was not sure why R #1 was taken off the 1:1 or when. CNA E said R #1 wore the wander guard on his wrist. CNA E said if R #1 got too close to the doors, the door alarms rang. CNA E said she was not sure how R #1 had the strength to get out the window but that was how she was informed that he eloped. CNA E said R #1 walked, but more like shuffled his feet, to move around. CNA E said she had seen R #1 got aggressive with staff in the past and tried to hit. CNA E said R #1 also got verbally aggressive and yelled at staff to get away. CNA E said she worked with R #1 the days before he eloped, and R #1 was a bit slower than normal. CNA E said ever since R #1 returned from the hospital, he seemed a little more declined, and less ambulatory. CNA E said R #1 was more confused at times or he said things like that he was leaving or that he was going to get his car. CNA E said R #1 would say things that were not actually happening. CNA E said R #1 also asked where the exit was or tried to go towards the door, but they redirected him back. CNA E said R #1 never said he was going to escape or that he was going to go out the window. CNA E said the staff knew if a resident had any change and they would tell them, so they knew to report if there were any other changes or different behaviors. CNA E said she was informed about the incident, and they did an in-service for elopements, abuse/neglect, and what to do if someone was missing. CNA E said they also did elopement drills to practice. CNA E said if a resident was missing, if they heard the door alarm going off, check the area first, check the area outside to see if they got out, check the rooms nearby, report as soon as possible to the nurse, and the nurse would take over and give them further instructions. CNA E said if the resident was not found, maybe also call the police. CNA E said before the incident happened with R #1, she had been in-serviced for elopements and already knew what to do. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455560	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Nursing Center	600 N Cynthia St McAllen, TX 78501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN B on 07/25/24 at 3:50 PM revealed LVN B said she worked on the 10 PM-6 AM shift but also worked on the other shifts as needed. LVN B said there were several residents that wore the wander guard for their safety because they tried to exit seek so the door alarms rang if the residents got too close. LVN B said that included R #1. LVN B said on 07/19/24, R #1 needed to go to the restroom at around 6:30 PM-7 PM, so she assisted him in the men's shower restroom. LVN B said after R #1 finished, she redirected R #1 back to his hallway, but R #1 decided to sit in a chair by the nurse's station, which he would usually do. LVN B said she continued with her assignments. LVN B said she saw R #1 walk around and that was the last time she saw R #1. LVN B said she saw when LE arrived as she walked back to the nurse's station. LVN B said LE asked if she had an identification for R #1 and LVN B showed her the photo on his file. LVN B said LE verified R #1 was the individual LE had in their custody. LVN B said LE's partner brought R #1 to the front of the building and RN G went out to get him. LVN B said LVN A was on the phone with the DON. LVN B said R #1 had a shuffling gait and walked slowly so they brought his wheelchair outside to assist him. LVN B said RN G took R #1 to his room and assessed him. LVN B said she was not there during the assessments. LVN B said R #1 did not appear to be injured but he was a little sweaty. LVN B said it was humid that day. LVN B said she did not think R #1 looked dehydrated. LVN B said LE brought R #1 back around 8 PM. LVN B said R #1's usual questions were that how far his home was, where did the bus stop, and he would say that the facility was not his home and asked to call his family member. LVN B said those were not abnormal comments or behaviors for him. LVN B said that was the reason why R #1 had the wander guard in place, because he tried to go towards the exit doors. LVN B said R #1 was easily redirectable. LVN B said she had been assigned to him recently before this happened and he also tried to exit seek during the overnight shift. LVN B said she did not remember the exact date, but she documented in her notes. LVN B said she just redirected him. LVN B said R #1 never said he was going to go out the window or tried to get out the window. LVN B said R #1 had finished his antibiotics he was on because he had ESBL (bacterial infection) to the urine. LVN B said it had been like a week before the recent incident happened that he had finished his antibiotics. LVN B said R #1 was confused at times even if he did not have a UTI. LVN B said R #1 had good days with no behaviors and then other days he would be very forgetful and even aggressive. LVN B said she had seen R #1 be aggressive towards staff, cussing at staff, trying to punch them, so both physically and verbally aggressive. LVN B said the DON or administration and the doctor decided if they placed him on a 1:1 from what she knew. LVN B said R #1 was placed on a 1:1 after the incident. LVN B said they also notified the DON, doctor, and family, which was the protocol for an elopement. LVN B said she was provided with in-services starting that night and the following days. LVN B said the in-services were for elopements and they also did elopement drills. LVN B said even before this happened, she had been in-serviced for elopements and it was not something new they learned. LVN B said they were also informed that they placed window alarms for those residents that have the wander guard which included R #1. LVN B said R #1 walked, like shuffled, not walked like normal, but he was on a mission and wanted to leave all the time. LVN B said R #1 did not get hurt from eloping, but he could have gotten hurt since he was not always fully alert, and he was sometimes more confused. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN C on 07/25/24 at 4:30 PM revealed LVN C said he worked on the 2 PM-10 PM shift. LVN C said he worked with R #1 and was familiar with him. LVN C said he did not work on the day R #1 eloped. LVN C said R #1 tried to exit seek multiple times since his admission. LVN C said R #1 was on a 1:1 basically since he was admitted . LVN C said R #1 was sent to the hospital on 07/01/24 and after he returned, R #1 was no longer on the 1:1. LVN C said R #1 was sent to the hospital for a fall, but he resulted with no serious injury. LVN C said R #1 was sent to the hospital more as a precaution. LVN C said R #1 was no longer on a 1:1 but he was not sure who decided the 1:1 or took him off it. LVN C said R #1 wore the wander guard since his admission and still currently wore it. LVN C said if R #1 got too close to the doors, the alarms rang. LVN C said the staff had to constantly redirect R #1 and he would sometimes get ups [TRUNCATED]