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	10/28/2024

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	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** 48278 Based on observation, interview and record review, the facility failed to ensure adequate supervision was provided for 1 of 6 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility and was found by the police department approximately 0.2 miles away from the facility. The Immediate Jeopardy template was provided to the facility on [DATE] at 4:38 p.m. While the Immediate Jeopardy was removed on 10/26/2024 at 1:33 p.m., the facility remained out of compliance at a scope of isolated and severity level of potential for more than minimal harm because all staff was not aware of and did not implement the facility's elopement procedures. This failure could prevent residents from receiving appropriate supervision which could lead to resident sustaining serious injury, harm, or death. Findings included: Record review of Resident #1's electronic facility face sheet dated 10/24/2024, revealed he was an [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included Alzheimer's, Bipolar, Post Traumatic Stress Disorder, Major Depressive Disorder, and Unspecified Dementia. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed he scored a 10 on his BIMS which indicated he was moderately cognitively impaired. Resident #1 functional abilities indicated he was independent for everyday activities. Record review of Resident #1's Elopement/Wandering Risk assessment dated [DATE] revealed low elopement risk. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a progress note dated 10/11/2023, revealed at 12:30 am Resident #1 was missing from room. Resident #1 was last seen in room at 11:15 pm. A silver alert activated. The staff was alerted in the facility and a surrounding search was initiated. At approximately 12:35 am Resident #1 was picked up at a convenience store. No injuries noted to Resident #1. As per Resident #1 voiced he exited through the front door, and he was wanting to go home. The MD and RP notified. A full body assessment was completed, vital signs were taken and within normal limits, and a wander guard bracelet was placed. One to One monitoring initiated. During an interview on 10/24/2024 at 11:10am Resident #1 stated he did not remember the incident. During an interview on 10/25/2024 at 10:30 a.m. CNA B stated he was assigned to work in the hall that Resident #1 was at. He did work the night of the incident. He stated that he was in the break room when LVN A and LVN D asked him where Resident #1 was at. CNA B stated that a code silver was activated by LVN A. He heard the front door alarm going off once he was out of the break room. He was not sure if it was him or LVN A who turned off the alarm because he was heading out the front door to go look around the outside perimeter. He stated that it wasn't the wander guard alarm that sounded, it was the front door alarm. CNA B stated that he saw the police at the nearby convenience store then he saw Resident #1. He stated they had an in-service for elopement done the following day. During an interview on 10/24/2024 at 3:37 p.m. LVN A stated she was Resident #1's nurse the night of the incident and she didn't hear the alarm. She was in the break room at the time when she was notified by LVN D that Resident #1 was not in his room. She stated CNA B was with her in the break room. They both got up and she initiated code silver alert. She called DON. At around 12:35 a.m. CNA B called her to notify her of Resident #1 being found at a nearby convenient store standing with a police officer. Resident #1 told LVN A that he was going home. She assessed him right away. LVN A stated he was last seen in the facility around 11:15 p.m. by LVN D. LVN A asked him how he got out of facility, and he said through the front door. A few minutes later she asked him again and he said he couldn't remember. Interventions that were put into place were a wander guard, 1:1 monitoring initiated, an in-service for a missing resident and an elopement drill completed. During an interview on 10/25/2024 at 9:12 a.m. LVN D stated that it was her second day on the job and she was being trained by LVN A the night of the incident. She stated she thought she heard an alarm earlier that night when she was at the vending machine. She was hearing something that did not sound like a call light but by the time she walked to the nurse's station, the sound was off. Then 30 minutes later, around 12:30 a. m. it was during that time that she walked by Resident #1's room and did not see him in his bed. She then went to get LVN A and CNA B, who were in the break room, and notified them that Resident #1 was not in his room. She was instructed to look inside the facility and then outside by LVN A. She did not recall hearing an alarm when going out of the facility to look on the outside perimeter. During an interview on 10/25/2024 at 9:42 a.m. LVN E stated she worked the night of the incident in another hall. She stated that she was in the room with a resident, and she did not hear an alarm. She did not know that Resident #1 was missing until a code silver alert was announced. She stated the only way they could leave facility was if they know the code. LVN E stated in-services were done on a missing resident and she thought an elopement drill as well. During an interview on 10/25/2024 at 11:15 am CNA F stated she worked the night of the incident in another hall. She stated she did not hear the alarm go off that night. (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 10/24/2024 at 1:50 pm the DON stated Resident #1 was missing for about 35-45 minutes. The DON stated she was notified at 12:35 am Resident #1 was not in his room and a code silver was initiated. The DON stated that a head-to-toe assessment be done, hydration assessment, pain assessment, and elopement assessment. The DON confirmed with Staff A the MD and RP had been notified. The facilityinitiated posttest training and in serviced all staff on the missing resident policy. The facility also conducted a mock drill silver alertThe DON stated they did 100% elopement assessments on all residents. No additional elopement events had been identified since. During an interview on 09/20/2024 at 11:03a.m. the Administrator stated that he ensures that the staff were doing and following the elopement protocol by conducting periodic monthly elopement education and drills. He stated that the drills were unannounced. He stated that the front door code was changed monthly and as needed. Sometimes if they noticed the family member know the code then they change it right away. During an interview on 10/24/2024 at 2:28 p.m. the Administrator stated the staff took action immediately. She was notified and a code silver was initiated. A head to toe assessment was completed. The RP and medical director were notified. The interventions were discussed and put into place. The investigation was started right away. She stated the door codes are only given to staff. Door codes are changed monthly and on an as needed basis. The Administrator stated Resident #1 must have opened the door by holding it for 15 seconds but when they asked Resident #1 again how he left the facility, he states he cannot remember. She stated they had an elopement drill that evening and yesterday 10/23/2024. In-services were also done for a missing resident and pretest/posttest, so staff know code silver. Record review of where Resident #1 was found approximately 0.2 miles away from the facility and the street speed was 30 miles per hour. This information was gathered by using google maps. Record review of a policy with date implemented of 10/24/2022 titled Missing Resident Policy revealed Policy: The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: Elopement occurs when a resident leaves the premises or a safe area without the authorization (i. e. an order for discharge or leave of absence), and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 2. Staff are to be vigilant in responding to alarms in a timely manner. 3. 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering including identification and assessment of risk evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. On 10/25/2024 at 4:38 p.m., the Administrator was informed of the Immediate Jeopardy and the plan of removal was requested (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The plan of removal was accepted on 10/26/2024 at 1:33pm. 1.Immediate Action Taken On 10/11/2024 The DON/ Designee completed a head-to-toe physical assessment with no negative findings noted On 10/11/2024 [Resident #1] was returned back to the facility and wander guard bracelet placed on resident On 10/11/24 [Resident #1] was returned back to the facility and placed on 1:1 observation. On 10/11/24 The DON/ Designee updated [Resident #1] care plan for wandering/exit seeking. On 10/11/24 The DON/ Designee completed elopement assessments on all facility residents with no changes noted. On 10/11/24 The maintenance director/ Designee completed environmental assessments to include checks on all door alarms and windows. On 10/11/24 The DON/ Designee completed in-service education with facility direct care staff on the missing resident policy which ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. On 10/11/24 The DON/ Designee completed a Missing Resident Drill with facility direct care staff to ensure staff know the proper procedure for locating missing residents to include when a staff member hears the alarm sound they will initiate the code silver alert to notify all other staff members of the missing resident and to not turn the alarm sound off until all staff are notified of the missing resident and headcount guidelines which requires visual confirmation and documentation regarding the location of each resident in the center. On 10/25/24 The facility administrator spoke with tech support in regards to functioning door alarm who stated alarm volume could not be adjusted and is functioning at manufacture guidelines. Verification: Started on 10/26/2024 at 10:38 a.m. and included: The following observations, record reviews and interviews were conducted by the survey team to ensure the staff's understanding on in-service trainings received between 10/11/2024 and 10/25/2024: Observation on 10/23/2024 at 2:15 p.m. LVN G verified with surveyor that Resident #1's wander guard and window alarm was functioning properly. Observation on 10/24/24 on 9:30 a.m. ensured that all the door alarms were functioning properly. Observation on 10/26/2024 at 11:36 a.m. Resident #1 was observed lying down in bed in his room asleep. There was a wander guard on his right wrist. (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 the completed head to toe assessment was done on 10/11/2024 and it had no negative findings. The 1:1 observation completed. The care plan was updated, and the elopement/wandering risk assessment was updated on 10/11/24. Resident was scored 8 at risk for elopement or unsafe wandering. The elopement assessments were done on all the residents. Record review of an In-Service Attendance Record with topic of Missing Person Alarm System, revealed that all staff was in-serviced on 10/25/2024. Record review of an In-Service Attendance Record with topic of Silver Alert, revealed that all staff was in-serviced and the elopement drill was done on 10/25/2024. During interviews on 10/27/2024 from 03:15 p.m. to 11:45 p.m., 3 CNAs, 4 LVNs, 2 Dietary/Kitchen staff, Receptionist, Central Supply Staff, Social Worker and Human Resource Staff were all knowledgeable of the missing resident policy and procedure. They were aware of the new expectations to not turn the alarm sound off until all staff were notified of the missing resident and headcount guidelines which required visual confirmation and documentation regarding the location of each resident in the center. During an interview via telephone on 10/27/2024 at 11:45 p.m., LVN A was able to verbalize understanding of the following in services received: Missing Person Alarm System and Silver Alert. During interviews on 10/28/2024 from 12:01 a.m. to 10:44 a.m., 2 RNs, 4 LVNs, 5 CNAs, Restorative Aide, Rehab Tech, Director of Rehab, 2 Housekeeping/Laundry, and Floor Technician were all were knowledgeable of the missing person policy and procedure, all were aware of the new expectations to not turn the alarm sound off until all staff are notified of the missing resident and headcount guidelines which requires visual confirmation and documentation regarding the location of each resident in the center. During an interview via telephone on 10/28/2024 at 10:44 a.m., CNA B was able to verbalize understanding of the following in services received: Missing Person Alarm System and Silver Alert. On 10/25/2024 at 4:38 p.m., the Administrator was informed of the Immediate Jeopardy. Verification of the plan of removal immediacy was completed prior to exit. The Immediate Jeopardy began on 10/25/2024 and ended on 10/26/2024.