STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455592	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Side Campus of Care	1950 S Las Vegas Trail White Settlement, TX 76108

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44970 Based on interview and record review the facility failed to complete a significant change of condition assessment within 14 days of determining or should have determined that there had been a significant changed in a resident physical or mental condition for 1 (Resident #25) of 3 residents review for significant changes of condition. The facility failed to complete a significant change of condition MDS assessment when Resident #25 attempted to leave the facility on 01/30/24. This failure could affect residents by placing them at risk for not receiving correct care and services leading to deterioration in their condition. Findings included: Record review of Resident#25's face sheet dated 02/12/24 was a [AGE] year-old male admitted on [DATE] with diagnoses including Major depressive disorder (sadness), recurrent, unspecified, Unspecified dementia (cognitive decline), moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety insomnia (difficulty sleeping). Record review of Resident #25's quarterly MDS assessment dated [DATE] reflected a BIMS score of 9 indicating he was moderately impaired cognitively, supervision of 1 person assist with hygiene task. Resident #25's mood, depression, hearing deficit, and dementia was addressed in MDS. Record review of Resident #25's care plan dated 02/14/24, reflected the resident was at risk for wandering/elopement and he has made attempts to exit the facility and has been moved to the secure unit for safety .Interventions include providing clear, simple instructions, Provide re-orientation to surroundings, environment .The resident has impaired cognitive function and short term memory loss r/t Dementia . interventions, Administer meds as ordered, communicate with the family and resident, use resident preferred name, discuss concerns of confusion, disease process report changes to MD. Record review of Resident #25's progress note dated 01/31/24 reflected 1/3 of room change resident alert has no complaints about room or changes. lying in bed with eyes closed will continue to monitor throughout this shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #25's progress note dated 01/30/24 by SW reflected Social services spoke with the resident's FM, , to inform them that the resident has tried to exit the facility. Social services re-iterated that when they met with the resident, on Saturday, it was explained to them that the resident would eventually have a roommate due to the resident staying in the facility for LTC. Everyone agreed with that on Saturday, including the resident. Social services explained that the resident received a roommate today and began to exhibit behaviors, not because of the roommate but because the resident does not want a roommate. It was also explained on Saturday that the resident has not been deemed safe to go out on pass independently and does require supervision. The resident's FM verbalized their understanding and agreed that that was discussed on Saturday. Social services informed them that the resident exited the facility from a side door, however, staff got to the resident quickly and re-directed the resident back into the facility, however, due to that the resident will be moving to the secure unit. The resident's FM verbalized their understanding and agreed with moving the resident to the secure unit. Record review of Care Plan Conference and IDT 02/01/24 reflected Resident #25 was a 1-person physical assist pt is hard of hearing . the residents usual performance based on the review of the functional abilities and goals assessments were addressed .room change no complaints of room no signs of distress . will continue to monitor throughout this shift moved to 400 locked unit due to exit seeking. FMs was concerned about confusion and stated she thinks he has Dementia. explained that he does have an actual Dementia Dx. No other concerns, resident to remain LTC. Record review of Resident elopement assessment dated [DATE], indicated he was low risk for elopement scoring a 1 indicating he was not risk for elopement. The assessment did not indicate the author. Record review of Resident #25's psych services assessment reflected a date of service of 02/1/24 Pt is located on locked unit in order to satisfy his desire to have no roommate .Depression: Staff reports current symptoms of sad moods, fatigue and feelings of worthlessness and reports no current symptoms of loss of interest, guilt, psychomotor agitation, psychomotor slowing, decreased concentration, suicidal ideation/intent/plan and appetite change. Staff reports history of sad moods, fatigue and feelings of worthlessness and reports no history of loss of interest, guilt, psychomotor agitation, psychomotor slowing, decreased concentration, suicidal ideation/intent/plan, and appetite change. Severity is level 4 (Moderate) Cognitive Impairment: Staff reports current symptoms of forgetfulness and confusion and reports no current symptoms of sundowning, incoherent speech, aggression towards others, wandering, mood/personality change, hoarding, word-finding difficulties and difficulties with ADLs. Staff reports no history of forgetfulness, confusion, sundowning, incoherent speech, aggression towards others, wandering, mood/personality change, hoarding, word-finding difficulties and difficulties with ADLs. Severity is level 4 (Moderate). In an interview with the SW/AIT on 02/12/24 at 1:15 PM revealed she was notified by ADON of the attempted exit the building after a conversation with his sister regarding room change to long term hall. He asked to return to previous placement. FM explained the need for change, and the resident asked to return to his room. She said approximately 1 hour later Resident #25 attempted to go out the side door on the 300 halls. Resident #25 verbalized understanding of the need for him to be placed on the memory unit. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/12/24 with ADON at 1:22 PM revealed on 01/30/24 duty the day of the incident. She was notified by charge nurse that Resident #25 attempted to exit the south door setting the alarm off upon opening. Nurse redirected resident away from the door and notified ADON. She maintained supervision of Resident #25 until notification to Administrator was completed to move resident to the locked unit for his safety. Resident was educated, assessed for injuries, vitals, family were notified, and he was monitored for 72 hours on the locked unit. In an interview on 02/12/24 at 1:45 PM with MD revealed nursing staff notified him on 01/30/24 of Resident #25's tried to exit the building, and he approved for him to be moved to the secure unit as the resident has an increase in confusion, memory loss. During an interview on 02/12/24 at 2:00 PM with the ADM, revealed that Resident #25's elopement assessment should have been updated to reflect the exit, and rationale for change on the memory unit for increased supervision. ADM stated that failing to reassess Resident #25, could have led other exit incidents and possibly harm. In an interview with the CN-RN corporate nurse on 02/14/24 at 3:35 PM revealed staff all nursing staff were in-serviced 02/12/24 that when a resident has a change in cognition, behaviors of exit seeking, a new assessment must be completed, reported, and interventions implement to prevent further exit attempts. Corporate nurse stated that it was the responsibility for the Charge nurses, ADON, and DON to monitor and audit assessments for accuracy and implementation of interventions to maintain resident's safety. She stated that the DON was out on medical leave, and she was responsible for monitoring. Record review of Inservice dated 02/12/24, 02/13/24 reflected updating of assessments immediately after an incident or attempt, notify abuse coordinator, MD, family once the resident was safe Resident Rights. resident has a right to be treated in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. Record review of facility locked secure unit elopement binder was reviewed and Resident #25 was listed with interventions and precautions for all staff to reference in the event of an elopement. Record review of a facility's policy titled Wandering/Elopement Risk assessment dated ,d+[DATE] reflected The Licensed Nurse, in collaboration with the I interdisciplinary Team (IDT), will assess res idents upon identification of s significant change in condition to determine their risk of wandering/elopement The resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition .IDT may consider interventions listed in Elopement Risk Reduction Approaches for residents identified to be at risk for elopement .Residents with a history of wandering or who IDT have assessed to be at risk for wandering or elopement will have a photograph maintained in their medical record and the Elopement/Wandering Risk Binder .Facility Staff will reinforce proper procedures for leaving the Facility for residents assessed to be at risk of elopement .If Facility Staff observes a resident leaving the premises without having followed proper procedures, he/she may: Try to prevent the departure in a courteous manner; Get help from other Facility Staff in the immediate vicinity, if necessary; and Direct another Facility Staff member to inform the Charge Nurse or Director of Nursing Services that a resident is trying to leave the premises.