STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46447 Based on observations, interviews, and record review the facility failed to post in a place readily accessible to residents, family members, and legal representatives of residents, the results of the most recent survey of the facility for 1 of 4 days (09/04/2024), observed for postings. The facility failed to ensure the survey results were available and accessible to residents and visitors without having to ask for them on 09/04/2024. This failure resulted in residents, family members, and legal representatives of residents being unable to access prior survey results without having to ask to see them. The findings were: During an observation on 09/04/2024 at 12:43 p.m. during a facility tour, revealed no survey results binder or sign indicating the location of the survey results was posted anywhere in the facility. During an interview on 09/04/2024 at 12:57 p.m. with the RECPST, she stated that she thought that the facility survey results book was in the facility copy room but was not sure. She stated that she would go ask the DON. During an interview on 09/04/2024 at 01:03 p.m. with the ADMIN, she stated that everything was recently moved during the facility's administration transition, so they were looking for the location of the survey results book. During an interview and observation on 09/04/2024 at 01:45 p.m. with the RECPST, she stated she located the facility survey results book in the Medical Records office. The RECPST was holding the facility survey results book, a white binder during the interview. During an interview on 09/05/2024 at 02:55 p.m. with the ADMIN, she stated she was not sure if the facility had a policy for ensuring that the survey results were available and accessible to residents and facility visitors but knew that it was a regulation or requirement. (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
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 09/07/2024 at 04:25 p.m. with the DON, she stated that she knew the prior administrator had the survey book moved due to a facility renovation. She stated that after the prior administrator left, the facility staff had difficulty locating some of the items moved. The DON stated the survey book was supposed to be available to anyone that would want to review what the facility had been cited on, that the survey results were public access, and that the survey results were available to ensure that the facility did not appear as if they were hiding anything. Record review of the facility policy, Examination of Survey Results, dated revised April 2017, revealed Survey reports and plans of correction are readily accessible to the resident, family members, resident representatives and to the public .2. A copy of the most recent survey report and any plans of correction are kept in visible site and easily accessible.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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** 46447 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent elopement for one (1) of four (4) residents (Resident #1) reviewed for accident hazards and supervision. The facility failed to ensure a cognitively impaired resident (Resident #1) had adequate supervision on 09/01/2024 which allowed him to elope from the facility from an unknown door after lunch on 09/01/2024 and was not located until 02:40 a.m. on 09/02/2024 at a local hospital. This failure resulted in the identification of an Immediate Jeopardy (IJ) on 09/05/2024 at 04:24 p.m. The IJ template was provided to the facility on [DATE] at 05:17 p.m. While the IJ was removed on 09/08/2024 at 02:14 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk for serious injuries and accidents. Findings included: Record review of Resident #1's Admission Record, dated 09/04/2024, revealed Resident #1 was a [AGE] year-old male admitted on [DATE] from an acute care hospital. Record review of Resident #1's Diagnosis Report, dated 09/04/2024, revealed Resident #1 was diagnosed with dementia (a general term for impaired ability to remember, think, or make decisions) during his stay at the facility, the onset of the diagnosis was dated 08/16/2024. Resident #1 had additional diagnoses which included: hypertension (a condition of high pressure in the vessels that carry blood from the heart to the rest of the body), muscle weakness, and alcohol use. Record review of Resident #1's MDS BIMS assessment, dated 07/02/2024, revealed a score of 2.0, indicating the resident had severe cognitive impairment. A second MDS BIMS assessment, dated 07/18/2024, revealed a score of 2.0, indicating the resident had severe cognitive impairment. Record review of Resident #1's Order Recap Report, order date: 06/26/2024 - 09/30/2024, revealed the following orders: - Add Dementia with Behaviors to diagnosis list, ordered date 07/09/2024 - May go on leave of absence with medications and responsible party, ordered date 06/26/2024 - q1hr (every one hour) checks monitoring for elopement risk every hour for elopement risk, ordered date 09/03/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Record review of Resident #1's Community Safety Awareness Summary assessment, dated 06/26/2024, revealed Resident #1 was moderately impaired for his ability to make decisions regarding tasks of daily living. Resident #1 was indicated to be unsafe for being capable of safely crossing the street without or without light, was not safe to leave the facility on pass, and was easily confused and could become lost. Record review of Resident #1's Elopement Risk Assessment, dated 06/26/2024, indicated Resident #1 had dementia and ambulated independently. He was cognitively impaired with poor decision-making skills, had a substance use disorder, and was at risk for elopement. He was indicated as at risk for elopement. Record review of Resident #1's Psychiatry Initial Evaluation, dated 07/09/2024, revealed Nurse reports pt (patient) with attempts to elope last week, however none this week. He was easily redirectable by staff at times of elopement attempts. He is ambulatory with no recent falls. Under Assessment and Plan, revealed 1. Dementia with behaviors: Noted recall issues and memory impairment .Pt with recent elopement attempts from facility Provide supportive cues and redirection Expect further decline secondary to disease course Orders written to add diagnosis to medical diagnosis list. Record review of Resident #1's Care Plan, accessed 09/04/2024, revealed Resident #1 with focus for having been at risk for elopement and had left the faciity on [DATE]. Focus initiated on 07/01/2024 and revised on 09/04/2024. Interventions included: Assess for risk of elopement per living center policy, initiated 07/01/2024; Involve patient in preferred activities, initiated 09/04/2024; and Redirect patients from doors, initiated 09/04/2024. Record review of Resident #1's Out of Facility Release of Responsibility Sheet, undated, revealed a document with two main columns titled, 'SIGNING OUT' and 'SIGNING IN', with each column having a location to document the date, time, and signature. Above the columns revealed, Authorization must be signed by the resident, or by the nearest relative in the case of a minor or when resident is physically or mentally incompetent. Resident #1's sheet revealed no documented dates, times, or signatures for Resident #1 signing out or signing in. Record review of Resident #1's Progress Notes, dated 09/01/2024 at 07:24 p.m. by LPN A, revealed Resident left out of building has not returned, Resident known to ask if he can go outside and be easily redirected and told only with a staff or family member. Today resident did not ask and has not been seen since eating lunch in dining room. Record review of a police report, dated 09/01/2024 at 07:47 p.m., revealed at 06:38 p.m. on 09/01/2024 the PO was dispatched to the facility for a report of a missing person and a city-wide [NAME] (be on the lookout) was issued for Resident #1. The PO spoke to LPN A, who stated Resident #1 had last been seen around 11:00 a.m. The PO contacted missing persons and a silver alert (missing persons alert for an older adult) was entered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Record review of Resident #1's Progress Notes, dated 09/02/2024 at 02:40 a.m. by LPN B, revealed Received call from [hospital staff member at local hospital] stating resident was currently in the ED (emergency department). He was brought in @ 2000 (at 08:00 p.m.) for disorientation (confused and unable to think clearly), dehydration (condition of having not enough water in the body) and intoxication (state of having an altered mood and abilities caused by alcohol or drugs). Resident underwent testing that was WNL (testing results were within normal limits or ranges). 1L (liter) IV (intravenous) fluids given. Resident will be discharged . Record review of Resident #1's Hospital Notes, dated 09/04/2024, revealed Resident #1 arrived at the emergency roiagnom on [DATE] at 08:26 p.m. via EMS (emergency medical services) with complaints of weakness prior to arrival. Resident #1's stated complaint was noted as weakness with a chief complaint of fall, trauma. Per the initial comments, .patient was a poor historian and had a very confusing story where he was walking outside possibly fell and had urinated oneself. Patient states he was walking outside felt weak as though he was about to fall but was able to catch himself. Resident #1's skin was noted as warm, non-mottled (not patchy or with irregular colors), no rashes. Resident #1's laboratory results, dated 09/01/2024 at 08:57 p.m. revealed an ethyl alcohol level of 24 (a level less than 50 mg/dL would not be considered not intoxicated). A chest x-ray (a type of scan to create detailed images of your bones) and head or brain CT (a type of scan to create detailed images of your bones and soft tissues) revealed no acute injuries. Resident #1's clinical impression was noted as dehydration after exertion. Record review of Resident #1's Progress Notes, dated 09/02/2024 at 04:05 a.m. by LPN B, revealed Resident arrived to facility via EMS x 2 in stable condition via stretcher. No N/O (new orders) per discharge papers. During an interview on 09/04/2024 at 04:10 p.m. with the DON and the RECPST, the DON revealed the front facility door was unlocked on weekdays (Monday through Friday) from 08:00 a.m. to 05:00 p.m. and monitored by the RECPST. The DON stated the doorbell outside the front doors was to be used for anyone wanting to enter the facility after those hours or on the weekend and the weekend supervisor or nurses stationed at the South Nursing Station could hear the doorbell and respond. The RECPST revealed the nurses had the code to the front door alarm if the alarm was triggered and stated the alarm would automatically go off after two to three minutes. During an observation and interview with the DON on 09/04/2024 of the facility doors from 04:10 p.m. to 04:32 p.m., the facility was observed to have fourteen (14) exterior or exit doors. The front access doors and the laundry access doors each consisted of two doors for access. Additional exterior doors were noted in several resident rooms, but those doors did not have exterior access due to installed deadbolts on the doors with no handle available to operate or attempt to open. The laundry access double doors and a side access door, labeled Door #5, were observed to have a push button or push pad next to the door to disable the door's alarm. The DON revealed Door #5 had the side button and a clicker that allowed staff to disable the door's alarm. The DON revealed Door #5 was used by EMS, resident transport services including to dialysis appointments, and by the facility driver to pick up and return residents into and out of the facility. During an interview on 09/04/2024 at 04:28 p.m. with the ADMIN and the DON, they revealed it was unknown what door Resident #1 eloped from. The ADMIN revealed she did not yet have access to the facility's camera system, due to having been a new employee, and had therefore been unable to review the camera footage of the doors during her incident investigation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	During an interview on 09/04/2024 at 03:18 p.m. with Resident #1, he revealed he believed he had lived at the facility for about four years and liked to leave. Resident #1 stated he left the faciity on Saturday or Sunday (he was not sure on the day of the week) with the intention of going to the bank. Resident #1 stated that he just went outside without telling anyone, through a door on the side of the building that one could go through. Resident #1 stated his bank was closed because it was a Sunday, and also stated that he couldn't find his bank or his bank's entrance. Resident #1 stated he was picked up by an ambulance and brought to a hospital. During an interview on 09/05/2024 at 09:15 a.m. and record review of the facility Incident Summary, dated 09/01/2024, the ADMIN read through the facility's Incident Summary. The Incident Summary revealed LPN A notified the ADMIN at 06:15 p.m. on 09/01/2024 that the staff were unable to locate Resident #1 and he was not present for the 05:45 p.m. medication pass. The ADMIN revealed the facility was not a locked facility but upon after-action review and to achieve the safest possible environment for the residents, the facility must secure the doors in such a way that residents that refused to follow facility protocols could be identified, alerting nursing as having left without signing out. The other solution was that noncompliant residents may be reviewed on a case-by-case basis to determine the at-risk nature of that specific resident and if the facility was capable of meeting their needs successfully. During an interview on 09/05/2024 at 10:46 a.m. with CNA C, she stated she worked Sunday, 09/01/2024 between 06:57 a.m. to 03:00 p.m. CNA C stated she did not recall seeing Resident #1 on Sunday and did not recall hearing any door alarms sounding during her shift. During an interview on 09/05/2024 at 01:34 p.m. with MA D, she stated she worked Sunday, 09/01/2024 from 02:00 p.m. to 10:00 p.m. MA D stated she provided Resident #1 with his medications on Sunday morning and remembered seeing him during the day walking to the dining room for coffee. MA D revealed she noticed around 5:30 p.m. to 6:00 p.m., while taking her assigned residents' blood pressures and issuing medications that she could not find Resident #1. MA D stated she checked Resident #1's room, the smoking area, and the dining area, the three areas Resident #1 was typically at but couldn't find him. MA D stated she then notified LPN A. MA D stated LPN A started directing staff to complete a facility search and had called the ADMIN. MA D stated she could not remember any door alarms sounding during the time Resident #1 was suspected as having gone missing. MA D revealed prior to Resident #1's elopement, he would sometimes ask her if he could check out and leave the facility, but he was easily redirected (change his focus to something else). MA D stated Resident #1 was initially antsy (anxious) when first admitted to the facility but had seemed to have calmed down. During an interview on 09/05/2024 at 01:48 p.m. with CNA E, she stated she worked Sunday, 09/01/2024 between 03:00 p.m. and 11:00 p.m. on Resident #1's hall. CNA E stated she did not recall seeing Resident #1 on Sunday and did not recall hearing any door alarms sounding during her shift. CNA E stated she observed an untouched lunch tray in Resident #1's room at the start of her shift (03:00 p.m.) and had notified the nurse, LPN A. CNA E stated she did not follow up with LPN A concerning the lunch tray because she had just started her shift and had left the follow up to the nurse. CNA E stated she believed Resident #1 was already missing at the time her shift began, 03:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	During a phone interview on 09/05/2024 at 02:13 p.m. with the Maint Dir, he stated due to having been out sick since prior to Resident #1's elopement, he had not been to the facility and had not had a chance to review the facility camera footage. He stated he was unaware of what door Resident #1 eloped from. The Maint Dir stated to his knowledge all the facility doors locked when closed and had alarms. The Maint Dir stated the only exception was the front door, which was open for visitors during work hours (Monday to Friday, 08:00 a.m. to 05:00 p.m.) and was scheduled to automatically lock and alarm at 05:00 p.m. The Maint Dir stated he would complete daily door checks during his morning rounds during the week and would sometimes check the building on Saturdays. During an observation on 09/05/2024 at 02:39 p.m. to 02:41 p.m., two facility staff were observed to separately push the button located next to Door #5, to disable the door's alarm, to exit the facility. A third staff member was observed pushing the button located next to Door #5 to let two individuals into the facility. The staff members were observed disabling the door's alarm in the view of a facility resident. During an interview on 09/05/2024 at 03:28 p.m. with CNA F, she stated she worked Sunday, 09/01/2024 between 03:00 p.m. and 11:00 p.m. on Resident #1's hall. CNA F stated she did not recall seeing Resident #1 on Sunday and was unsure of when Resident #1 had left the facility. CNA F stated she found out Resident #1 was missing around dinner time. CNA F stated during dinner tray delivery, CNA E had mentioned Resident #1's lunch tray was still in his room and untouched. CNA F stated that she had previously observed that Resident #1 would occasionally eat in the dining room. CNA F stated that she and CNA E told LPN A about Resident #1's lunch tray at that time and LPN A started making phone calls and asking staff to start searching the facility. CNA F stated she did not hear any door alarms sounding during her Sunday shift. During an interview on 09/06/2024 at 08:05 a.m. with LPN A, she stated she worked Sunday, 09/01/2024 between 07:00 a.m. and 07:00 p.m. LPN A stated she was covering the shift for another nurse and her assigned residents on Sunday were not her typical residents. LPN A stated she typically worked night shift. LPN A stated she had been assigned to Resident #1 before, but it was usually at night and he was either asleep or if he did get up, it was to go smoke. LPN A stated that the last time she recalled seeing Resident #1 on Sunday was around lunch time. She stated that he was walking the opposite way down the hall from her, and then she saw him again on her way back, eating lunch in the dining room. LPN A stated around 06:00 p.m. MA D notified her that she couldn't locate Resident #1, and Resident #1 was not supposed to be able to sign himself out without family because he had dementia. LPN A stated MA D had told her several times during the day that she was looking for Resident #1 but did not say anything about him not being able to sign himself out. LPN A stated she had known that the staff couldn't find Resident #1 but was not aware that he was not supposed to be able to sign himself out like the rest of the residents. LPN A stated she first checked the facility sign-out book and observed that Resident #1's page was blank. LPN A revealed she had not seen any interventions in place for staff to be able to identify which residents were not supposed to be able to sign themselves out. LPN A stated it was not until a shift following the incident that she observed a notice on the communication sheet that identified a different resident as not being allowed to sign himself out without family or other. LPN A stated that that was the first time she had seen a warning such as that. LPN A stated she had not considered Resident #1 an elopement risk because he would usually ask a staff member about signing out and he would allow the staff member to redirect him. LPN A stated prior to Resident #1's elopement, she had not seen any facility procedures in place to let the nursing staff know which residents were considered safe to sign themselves out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Record review of facility policy, Wandering and Elopements, dated revised March 2019, revealed, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. An Immediate Jeopardy (IJ) was identified on 09/05/2024 at 04:24 p.m. The IJ template was provided to the facility's ADMIN, DON, and RNC on 09/05/2024 at 05:17 p.m. A plan of removal was requested. On 09/06/2024, the facility provided a plan of removal titled: Plan of Removal for Immediate Jeopardy. The following plan of removal (POR) was accepted on 09/06/2024 at 03:16 p.m. PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it May Concern, Summary of details which leads to outcomes. On September 4, 2024, an investigation was initiated at [facility name and address]. At approximately 5:15p.m on September 5, 2024, a surveyor provided verbal notification that [state name] Health and Human Services had determined the conditions at [facility name] constitute immediate jeopardy to resident health and safety. The Immediate Jeopardy findings were identified in the following areas: F-0689 - Free of Accident Hazards/Supervision/Devices Immediate Corrections Implemented for Removal of Immediate Jeopardy. On September 2, 2024, at approximately 4:05am Resident#1 returned to the facility from the Emergency Department. Action: Resident #1 is a current resident and was brought back to facility on 9/2/2024. The resident was immediately assessed by the charge nurse and a head-to-toe assessment was completed. The responsible party, physician, DON and Administrator were notified of the resident's safe return. Resident#1 was placed on 15 minutes monitor checks for safety. A community safety awareness assessment for Resident #1 was completed by the DON. IDT reviewed and interventions initiated, and care plan updated reflect elopement risk. On September 1, 2024, at approximately 9:20pm the following action was taken: Action: Education initiated Elopement risk, Abuse/Neglect/Exploitation, Signs to watch for with residents exhibiting potential for elopement, increased wandering, exit seeking, increased behaviors. Start Date: 9/1/2024 Completion Date: 9/4/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Responsible: Administrator Action: Signs were posted on all doors, that were not already marked as emergency exit only, instructing all visitors and residents to enter and exit through main facility entrance only. Start Date: 9/1/2024 Completion Date: 9/1/2024 Responsible: Administrator 0n September 5, 2024, at approximately 6:00pm the following actions were taken: Action: Education initiated with all staff on Elopement, Abuse and Neglect, Resident Rights, Environment Free from Accident Hazards Start Date: 9/5/2024 Completion Date: 9/5/2024 Responsible: Administrator Action: Ad hoc QAPI meeting held with IDT team and MD to review policy on Elopement, Abuse and neglect, and Plan of removal/response to Immediate Jeopardy Citation on 9/5/2024 Start Date: 9/5/2024 Completion Date: 9/5/2024 Responsible: Administrator IDENTIFICATION OF OTHER AFFECTED: All residents have the potential to be affected. Action: Facility reviewed and ensured Elopement Risk Assessments were complete and current for all residents. 96 of 96 residents were reviewed. All residents identified as at risk of elopement were reviewed to have appropriate interventions and plan of care in place per risk assessment. 38 of 96 residents were newly identified as at risk for elopement. Physician and responsible parties were notified of assessment results and care plan interventions. Start Date: 9/5/2024 Completion Date: 9/5/2024 Responsible: Director of nursing/designee SYSTEMIC CHANGES AND/OR MEASURES: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Action: In-service and education was provided to facility staff regarding the process for residents who have been identified as an elopement risk and proper steps to take to assure residents remain safe without risk for elopement, including monitoring, and care plan updates. Start Date: 9/5/2024 Completion Date: 9/5/2024 Responsible Party: Director of Nursing/Designee Action: Education was provided to all staff on Elopement policy, Abuse/Neglect/Exploitation, Resident Rights, Free from Hazards, Notification of behaviors, wandering or elopement attempts, Start Date: 9/5/2024 Completion Date: 9/5/2024. Responsible Party: Director of Nursing/Designee Action: New position opened and assigned for evening and weekend monitoring by additional receptionist or security guard. Weekend receptionist or security guard will have access to resident list that will include photo of resident for identification and will verify any resident who has orders to sign self out on pass without accompaniment. Start Date: 09/06/2024 Completion Date: ongoing until position is filled Responsible Party: Administrator Action: Scheduled installation for alarms for 14 of 14 doors Start Date: 09/06/2024 Completion Date: 09/06/2024 Responsible Party: Maintenance Director/designee Action: Front doors to facility will be alarmed at all times. Access to front door will be monitored by receptionist Monday through Friday from 8am to 5pm. The South Nurses station will monitor access to the front entrance after hours and on the weekend. The receptionist will receive a current list of residents, that will include photo of resident for who may sign out without supervision, from the Director of Nurses. The list will be updated upon resident's admission, discharge, and change in status of resident condition after IDT and physician review. A copy will be available at each nurses' station. Start Date: 09/06/2024 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	Completion Date: 09/06/2024 Responsible Party: Administrator, Director of Nursing/Designee Tracking and Monitoring - Director of Nursing/Designee will review residents with At Risk for wandering or elopement identified or newly admitted with history of elopements to assure appropriate interventions and plan of care are in place 5 times per week beginning 9/5/2024 for 12 weeks or until sufficient compliance if found. This will be documented in daily clinical meeting with use of electronic log and reviewed monthly in QAPI meeting. - Administrator/designee will complete random audit every shift for 7 days, beginning 9/6/2024 for appropriate staff response to wandering or potentially exit seeking residents, immediate education will be provided, if necessary, then will monitor random shifts, 5 times a week for 12 weeks or until sufficient compliance if found. This will be documented on log to be reviewed in QAPI Meeting Monthly. - Administrator/designee will complete audit of exits for proper functioning of doors and alarms for proper functioning every shift for 7 days, beginning 9/5/2024 then will monitor random shifts, 5 times a week for 12 weeks or until sufficient compliance if found. This will be documented on log to be reviewed monthly in QAPI. - Any trends or concerns were/will be addressed with Quality Assurance Performance Committee and continue until a lessor frequency deemed appropriate through QAPI review The facility's POR Verification was as follows: During an observation on 09/06/2024 at 10:00 a.m., the R Maint Dir was observed installing new alarms on the facility front entry and exit doors. During an observation on 09/06/2024 from 10:00 a.m. to 08:00 p.m. multiple observations of observing and hearing the facility new door alarms sounding. Observations included staff and facility guests attempting to either enter or exit the facility, without the RECPST or a nurse with a door key disarming the door alarm. During an observation on 09/06/2024 at 04:33 p.m., a binder labeled Residents that may go out on pass without supervision, dated as edited on 09/06/2024 by the ADON was observed. The binder included the names and pictures of 23 residents. During an interview with the R Maint Dir on 09/06/2024 at 04:36 p.m., he stated he ordered fourteen (14) new door alarms for the facility and installed the alarms on ten (10) doors. He stated the additional four (4) doors already had a key alarm. He stated the new alarms required a key to deactivate and/or turn off the alarm and that the alarms would not stop sounding until they were deactivated. He stated that he was told the keys were to only be issued to the nurses, to put on their key rings, the charge nurse, the administrator, and the maintenance director. He stated the doors were to be alarmed at all times and they were battery powered, with the battery expected to only require replacement every 6 months to one year. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	During an observation and interview with the interim ADMIN on 09/06/2024 at 04:45 p.m., she showed the new job posting for a Receptionist on [a job posting website]. The job was noted to have been just posted. The job duties listed included: This position is for evening/Weekend Receptionist., Monitor the front door of the facility- who comes in/who leaves., and Complete the incident log on a daily basis. Record review of the facility POR Binder on 09/06/2024 at 06:52 p.m. revealed: a. A copy of the AD Hoc QAPI Meeting dated 09/05/2024 and noted with an agenda: IJ 6869 [sic] Review and Review Plan of Removal. Attendees were noted as: the DON, the MD, the ADMIN, and the RNC. b. A document labeled with five (5) areas to notate Staff Response to wandering or potentially exit seeking resident: 1. Have you identified any residents with new exit seeking behavior? 2. Have you identified any residents newly at risk for elopement? 3. Is any additional education needed at this time? Shift:_____ Time:_____ c. Seven (7) copies of the facility map, labeled Door Check and each subsequently dated from 09/05/2024 to 09/11/2024. The documents dated 09/05/2024 and 09/06/2024 reflected a X marked next to each location on the map where an exterior or exit door was located. The 09/05/2024 document was noted as completed on 09/05/2024 at 09:00 p.m. by the ADMIN. The 09/06/2024 document was noted as completed on 09/06/2024 at 11:00 a.m. and 03:00 p.m. by the interim ADMIN. d. Copies of the facility Daily Census Report, dated 09/05/2024 and 09/06/2024 with each resident named checked off. The documents were observed to be labeled by hand on each first page, Review at risk with an additional label stuck to the initial document, titled Review of residents at risk for Wandering or Elopement. e. A document labeled QAPI Addendum with the following noted under Agenda: Review facility plan of removal for Immediate Jeopardy Verification of audit completion: - DON review at risk for wandering or elopement identified or newly admitted with history of elopements to ensure appropriate interventions and plan of care are in place - 5 times a week beginning 09/05/2024 for 12 weeks - Staff response log to wandering or potentially exit seeking residents (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	- Every shift for 7 days, beginning 09/06/2024 - 5 times a week for 12 weeks - Exit audits completed - Every shift for 7 days beginning 09/05/2024 - 5 times a week for 12 weeks Review for trends identified: Record review of in-service documents included: - Document dated 09/05/2024 at 06:52 p.m. with topic CNA's will document new behaviors in POC (Plan of Care), notify charge nurse, DON, and administrator. The in-service had 29 CNA names as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topic Nurses will document in [Electronic Medical Record, EMR] new behaviors, notify DON, Administrator, and MD Immediately. Document with 6 RN names and 9 LVN names (15 total licensed nurses) noted as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topic Wandering and Elopements. The in-service had 52 nursing and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topic Wandering and Elopements. The in-service had 58 administrative, dietary, plant (housekeeping, laundry, maintenance, driver), and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topic Abuse and Neglect. The in-service had 52 nursing and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topics Abuse and Neglect and Resident Rights. The in-service had 58 administrative, dietary, plant, and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:52 p.m. with topic Safety and Supervision of Residents. The in-service had 58 administrative, dietary, plant, and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:53 p.m. with topic Safety and Supervision of Residents. The in-service had 51 nursing and therapy staff names noted as having received training. - Document dated 09/05/2024 at 06:53 p.m. with topic Resident Rights. The in-service had 51 nursing and therapy staff names noted as having received training. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455597	A. Building B. Wing	09/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Memorial Medical Nursing Center	307 W Cypress St San Antonio, TX 78212

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	- Document dated 09/06/2024 with topic Residents who can sign out on pass without being accompanied by supervision will be placed in a Binder which will be at Receptionist desk and each Nurses station. This will be maintained and updated by Nursing management when new admissions/discharges/ changes in condition or risk status change. The in-service had 111 facility staff names noted as having received training. Record review and interview with the DON and Th Dir on 09/06/2024 at an unknown time, of an undated listing of employee names divided per department and with each employee member's phone number and job title, revealed a total of 106 facility employees with an additional four (4) identified by the DON or Th Dir as gone or no longer employed. Of the four, three (3) were therapy staff and one (1) was an administrative staff. Twenty-two (22) staff were identified as not expected to be present in the facility for multiple days. Seven (7) therapy employees were identified as on vacation. Three (3) employees were out sick, one (1) from the plant department and two (2) from therapy. Eleven (11) employees were PRN (as needed), se [TRUNCATED]