STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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** 30664 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents reviewed for accidents and supervision. (Resident #1) The facility failed to provide adequate supervision for Resident #1 who was assessed as a high risk for elopement. On 01/22/24 he was allowed to sit on the front porch without supervision, and facility was contacted by equipment company next door that resident was there. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/22/2024 and ended on 01/22/2024. The facility had corrected the non-compliance before the survey began. This failure could prevent residents from receiving appropriate supervision which could lead to resident sustaining serious injury or harm. Findings included: Record review of an undated face sheet indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included congestive heart failure systolic and diastolic (a condition in which the heart's main pumping chamber (left ventricle) is weak, becomes stiff, and unable to fill properly), respiratory failure (a serious condition that makes it difficult to breathe on your own), hypertension (a condition in which the force of the blood against the artery walls is too high), atrial fibrillation (a type of irregular heartbeat), and cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off). Record review of hospital records with a History and Physical dated 01/12/2024 indicated Resident #1 had a history of methamphetamine abuse. Record review of an Elopement/Wandering Evaluation dated 01/19/2024 indicated Resident #1 was a high risk with a score of 25 out of 55. The form was signed by LVN B. (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	During an interview on 09/11/2024 at 11:43 a.m., LVN B said she had filled out the Elopement/Wandering Evaluation on Resident #1. She said she answered some of the questions based on the personal history of knowing Resident #1 and his drug abuse history and that was why it triggered him at high risk for elopement. Record review of a Brief Interview for Mental Status dated 01/22/2024 indicated Resident #1 had severely impaired cognition with a score of 04 out of 15. Record review of Progress Notes with a Nursing Note entry dated 01/22/2024 indicated Resident #1 had been at the nurses' station multiple times today asking to call his de-identified family member. RN A was able to get her on the phone for him and he was able to speak with her. After speaking with her, Resident #1 asked if he could leave the facility to go to the bank. RN A told him yes, he could but he needed to sign out and have a ride to take him and he stated that someone was going take him to the bank and he would be back in two hours. He then walked towards the front. RN A told him once again to let the nursing staff know that he was leaving and to come sign out. Resident #1 verbalized understanding. During an interview on 09/11/2024 at 11:17 a.m., RN A said Resident #1 came to the nurse station wanting to go the bank to get some money. RN A said she contacted the de-identified family member and Resident #1 spoke with de-identified family member on the phone. RN A said then Resident #1 went to the resident phone and had called someone. RN A said Resident #1 then came back to the desk and asked could he leave the facility to go to the bank and RN A told him yes but needed to sign out and have a ride to take him. RN A said he had a ride to take him and walked towards the front at which point she reminded him to let them know he was leaving and to come sign out. A Provider Investigation Report dated 01/30/2024 indicated the incident occurred on 01/22/24 at 01:00 p.m Resident #1 went on the front porch to sit and wait for a ride. He then unknowingly left the facility walked next door to a local business to ask for a ride to the bank. The facility initiated the elopement protocol when they realized he was not in the facility. The grounds were searched. Resident #1's de-identified family member was contacted who said she had not picked him up. During the search the local business contacted the facility to let them know Resident #1 had walked next door and asked for a ride to the bank. The Administrator and DON picked up the resident and returned him to the facility. A head-to-toe assessment was conducted with no negative findings. His de-identified family member was notified he was back at the facility and one on one monitoring was initiated. His physician arrived at the facility and assessed him with no negative findings. In-services were conducted with staff on elopement protocol, on accuracy of elopement assessments, and on residents sitting out front. All residents had updated elopement assessments conducted. The Elopement Binder was updated. Resident #1 continued on one-on-one monitoring until he was transferred to a secured unit facility. During an interview on 09/11/2024 at 02:18 p.m., the DON said they reviewed the camera on the front porch and it was approximately 10 minutes from the time Resident #1 started walking down the driveway to when the local business next door notified them the resident was at their business. (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 a Physician/NP/PA Progress Note/Discharge Summary dated 01/22/24 indicated Resident #1's physician examined the resident and indicated .clinically stable. continue lasix and atenolol. cardiac diet reviewed. ok for [discharge] home. [follow up] with [primary care physician] and cardiology within a week after [discharge]. [emergency room] warnings reviewed for chest pain/[shortness of breath] Record review of 15-Minute Checks form indicated Resident #1 was observed every 15 minutes from after he returned to the facility on [DATE] until he discharged to another facility on 01/25/24 at 05:45 p.m During an interview on 09/11/24 at 03:22 p.m., the DON said when Resident #1's physician examined him, he said Resident #1 could go home. She said she explained to the physician that Resident #1's de-identified family member did not want him to go home because of the drug abuse and his de-identified family friend was not a good influence. She said she told the physician the de-identified family member had the keys to Resident #1's home and would not give them to the facility or to the resident. She said at that time the QAA committee including Resident #1's physician who was the Medical Director reviewed everything. They decided to reeducate everyone on elopement, on accuracy of elopement assessments, and on residents sitting out front; assess all residents for elopement; update the elopement binder; Resident #1 was to be transferred to a facility with a secured unit; and he was to remain on one-on-one monitoring until his transfer. She said the information was all put into the QAPI report. She said Resident #1's de-identified family member was notified, and the de-identified family member agreed to the transfer. Record review of a policy with revision date of 12/2023 titled Elopement/Unsafe Wandering indicated Policy: It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. Definitions: Elopement occurs when a resident leaves the premises or a safe area without the facility's knowledge, authorization (i.e. an order for discharge, appointment, or leave of absence), and/or any necessary supervision to do so. Procedure: 1. Residents with capabilities of ambulation and/or mobility in wheelchair will have an Elopement/Wandering Evaluation completed to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempts to elope. 2. Residents with high risk factors will be identified as At Risk and will have an individualized care plan developed that includes measurable objectives and timeframes Record review of an In-Service Attendance Record with subject of Elopement Drill and Procedure, dated 01/22/2024, indicated that 57 staff members signed the in-service record including RN A, LVN B, and Receptionist C. Record review of Assessment History LN-Elopement/Wandering Evaluation list dated 01/22/24 at 04:44 p.m. indicated all residents in the facility were reassessed on 01/22/24. Record review of Incident logs from 01/22/24 through 09/12/24 indicated there were no other resident elopements from the facility. (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 09/11/24 at 10:45 a.m., the DON said the resident was low risk for elopement at the time of the incident. She said he followed someone out and was looking for his car in the parking lot to get him some beer. She said he was reassessed as high risk for elopement and placed in the binder. Record review of the Elopement Binder on 09/11/24 indicated it was updated to include current residents assessed as high risk for elopement. During observations on 09/11/24 from 09:00 a.m. - 09/12/24 10:30 a.m., of current residents at risk for elopement indicated staff maintained residents within eye contact and staff did not allow them to go outside of the facility without a staff member with them. During interviews on 09/11/2024 from 12:30 p.m. - 09/12/2024 10:30 a.m., 1 RN was able to identify residents at risk for elopement, was knowledgeable of the elopement policy and procedure, was aware of the new expectations to not allow any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone. During interviews on 09/11/2024 from 12:30 p.m. - 09/12/2024 10:30 a.m., 4 LVNs (2 from each shift) were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, all were aware of the new expectations to not allow any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone. During interviews on 9/11/2024 from 12:30 p.m. - 9/12/2024 10:30 a.m., 4 CNAs (2 from each shift) were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, all were aware of the new expectations to not allow any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone. During interviews on 09/11/2024 from 12:30 p.m. - 09/12/2024 10:30 a.m., 2 Receptionists were able were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, they were aware of the new expectations to not allow any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone. On 09/10/2024 at 04:59 p.m., the Administrator and DON were informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 01/22/2024 and ended on 01/22/2024. The facility had corrected the noncompliance before survey began.