

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455925	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Veranda Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 S Expressway 83 Harlingen, TX 78550	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32107</p> <p>50487</p> <p>Based on observation, interview and record review the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 7 residents (Resident #2) reviewed for accommodation of needs.</p> <p>The facility staff did not provide Resident #2 with a call light that was within reach.</p> <p>This failure could place residents who utilized call lights at risk for not having his/her needs met.</p> <p>Findings include:</p> <p>Record review of the admission record for Resident #2, dated 06/07/2023, reflected Resident #2 was admitted to the facility on [DATE]. Resident #2 was a [AGE] year-old female with diagnoses which included hemiplegia (paralysis of one side of body) and hemiparesis (weakness to one side of the body), following a cerebral infraction affecting right dominant side.</p> <p>Record review of Resident #2's comprehensive care plan, last revised on 1/05/24 , reflected a focus care area resident is at risk for falls psychotropic medication use, poor safety awareness s/p Cerebrovascular Accident, right sided weakness Interventions included be sure call light is within reach and encourage to use it for assistance as needed.</p> <p>Record review of Resident #2's admission MDS assessment, dated 1/22/24, reflected the cognitive status was severe cognitive impairment (decisions poor).</p> <p>Observation on 04/09/24 at 2:05 PM revealed Resident #2 was in bed, awake, and her call light was on the left side under the pillow out of reach from Resident #2. Resident #2 was observed attempting to reach the call light with her left hand and was not able to reach it.</p> <p>Interview on 4/09/24 at 2:07 PM, Resident #2 said the call light was used to call for assistance like when she needed to be changed or was cold. She said was not able to reach the call light under her pillow .</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 4/09/24 at 2:07 PM, CNA C said Resident #2 used the call light to ask for assistance, however the call light was under the pillow out of reach from the resident. He said call lights should be accessible to all resident who could use them. CNA C said if the call light was not accessible the resident could not have the assistance needed and could cause stress for the resident .</p> <p>Interview on 04/09/24 at 2:09 PM, LVN B said Resident #2 did use the call light, however, if the call light was under the pillow Resident #2 could not reach it. LVN B said if the call light was not accessible for Resident #2 staff would not know if she needed to be assisted. LVN B said if the call light was not accessible for Resident #2 it could cause anxiety if she needed to be assisted.</p> <p>Interview on 4/09/24 at 3:49 PM, the DON said, call lights should be accessible to residents to use them .</p> <p>Record review of the facility's, undated, policy titled Call light/Bell reflected, Leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40872</p> <p>Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one resident of 3 residents (Resident#1) reviewed for supervision.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure Resident #1 received adequate supervision when Resident #1 eloped from the facility on 12/06/23. Resident #1 was found by Driver A on 12/06/23 approximately 0.2 miles from facility near a highway. 2. The facility failed to implement interventions to prevent Resident #1's elopement from the facility. <p>The non-compliance was identified as PNC. The IJ began on 12/06/23 and ended on 12/07/23. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of injury or death.</p> <p>Findings include:</p> <p>Record review of Resident #1's Admission Record, dated 04/10/24, documented an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses which included unspecified Dementia (decline in cognitive abilities), Muscle weakness, Abnormalities of gait and mobility and Cognitive communication deficit (difficulty with communication).</p> <p>Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Brief Interview for Mental Status score of 2, which indicated severely impaired cognition.</p> <p>Record review of Resident #1's Elopement/Wandering Evaluation record, dated 12/6/23, reflected Resident #1 had a score of 13 and Category noted as High Risk.</p> <p>Record review of the Provider Investigation Report, dated 12/06/23, reflected Resident #1 was found at a Dialysis center by a Driver A. Driver A brought Resident #1 back to the facility. At 4:18 p.m. DON was notified and at 4:36 p.m. the resident was returned to facility with no injuries noted. The resident was no longer residing at the facility at the time of this investigation.</p> <p>In an interview on 04/10/24 at 9:08 a.m., the DON said Resident #1 left the facility and was found by the facility driver at a local dialysis center. She said they conducted an investigation. They reviewed the facility cameras and found Resident #1 exited the building from hall 300 at around 3:54 p.m. The DON said she did not know exactly how she ended up at the dialysis center. She said the area outside Hall 300 was fenced in. The DON said the facility driver found the resident around 4:07 p.m. and brought her back to the facility. She said Resident #1 was assessed and had a wander guard in place and had no injuries. DON said the cameras record for a short period of time and automatically record over. She did not have video of Resident #1 exiting facility saved for viewing.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/10/24 at 9:39 a.m., the Environmental Manager said Resident #1 left the facility from the exit door on hall 300. They reviewed the camera and found she went 3 times towards the exit trying to leave. She was able to get the door opened after a several attempts. The Environmental Manger said the door alarm did sound but it was not very loud. He said after the incident they placed another alarm near the top of the door. He said he was unsure how she left the premises since the area was fenced in. The Environmental Manager said they had a landscape company who went in every Wednesday and came in through that fenced area. He said there was a possibility the landscapers did not lock the fence or did not notice she walked out but he did not know if that was what happened. He said at the time, there was no one who verified if the fence was closed properly once they left the facility. Environmental Manager said after the elopement incident, he spoke to the contracted landscaping company and both he and the contractors will be ensuring the gates are closed and secured when they leave the facility grounds.</p> <p>In an interview on 04/10/24 at 10:01 a.m., LVN D said the day Resident #1 eloped, she was exit seeking. She said she redirected her at least once to the nurses station and Resident #1 went to the dining area where residents were participating in activities.</p> <p>In an interview on 04/10/24 at 10:22 a.m., Driver A said he was dropping off a resident at the dialysis center when he saw Resident #1 talking to a lady on the street at the dialysis center. He approached her and asked her to come with him back to the facility. He said she recognized him and appeared happy to see him and he was able to transport her back to the facility. Driver A said he called the facility to notify them he had found the resident at the dialysis center and was returning her back to the facility.</p> <p>In an interview on 04/10/24 at 2:56 p.m., the Activity Director said the day Resident #1 eloped, she was having an activity with the residents. She said Resident #1 was going towards the exit doors and she kept having to distract her with activities.</p> <p>In an interview on 04/10/24 at 3:00 p.m., CNA L said she conducted daily testing of door alarms for proper functioning and documented in the testing log. CNA L stated she also tested residents' wander guard bracelets for proper function.</p> <p>In an observation on 04/11/24 at 1:45 p.m. of hall 300 exit door located on north side of facility revealed door was equipped with code lock. Also noted was two white magnetic boxes at the top of the door. Further observation revealed door was programmed with delayed egress of 15 seconds. When door handle was held down door lock would release. The alarm was slightly audible, however, when door was ajar the alarm was audible at several decibels higher.</p> <p>In an observation on 04/11/24 at 1:50 p.m. revealed hall 300 exited into fenced off area of back yard. Gates were equipped with pool side gate latches.</p> <p>In an interview and observation on 04/11/24 at 2:20 p.m. with Environmental Manager revealed that after the resident was retrieved by the facility, he assessed the door Resident #1 had exited. The door was observed to function as designed. The Maintenance supervisor said they did notice that the door alarm was not audible, so additional door alarms were added to the top of the door.</p> <p>In an observation on 04/11/24 at 2:25 p.m. Environmental Manager engage two white magnetic boxes at the top of the door which initiated a high-pitched audible sound when door was open.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 04/11/24 at 2:45 p.m. with CNA L revealed she is in charge of testing the wander guard bracelets. CNA L said she checks every resident on the log to verify that the bracelets are placed as per orders and they are functional. If resident does not have guard on or it is not functional, she will get one from kit at nurses station. (Kit is a plastic box which contains parts for bracelets, replacement batteries and testing tool. Kit is located next to the wander guard log). CNA L said in addition to checking bracelets she also check that the locking mechanism at exit door is function properly. CNA L said only the main entrance is equipped with a wander guard lock, the rest of the doors only have alarms.</p> <p>In an interview on 04/11/24 at 2:50 pm CNA L demonstrated the use of testing wander guard device by walking towards system at which time there was an auditory signal and door lock engaged.</p> <p>In an observation on 04/11/24 at 2:55 p.m. CNA L demonstrated how bracelet was tested with resident by waving wand across bracelet.</p> <p>Record Review of Wander Guard Checklist dated April 2024 revealed daily testing of resident personal wander guards, photos of residents that are being monitored and documented daily testing log of wander guard bracelets.</p> <p>Record review of Resident #1's care plan, updated on 12/06/23, reflected the following interventions were put in place:</p> <ul style="list-style-type: none"> -check for wander guard placement. -structured activities -check door alarms are working properly -elopement assessment completed -door alarms tested daily & documented <p>Other precautions placed after incident were:</p> <ul style="list-style-type: none"> -Daily Checking of exit Doors -Secondary door alarm (hall 3) -Pull lever on outside fence door <p>Record Review revealed the following In-services conducted with staff after each incident:</p> <p>Topics: Elopement; abuse and neglect, missing resident policy and procedure, ensuring proper door engagement, fall and fall prevention.</p> <p>Dates: 12/06-12/23</p> <p>Staff Interviews / All shifts:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DON, ADON, LVN (3), RN (2), CMA (2), Environmental Manager, DON, . CNA's (4), Activity Director, Driver (1).</p> <p>All staff interviewed were informed and knowledgeable on facility policy and procedure related to identifying and monitoring residents with exit seeking tendencies, redirecting and ensuring residents at risk remained engaged.</p> <p>Record review of the facility's policy titled; Elopement / Unsafe Wandering Revised date 01/2022 states,</p> <p>Purpose: The facility is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing the resident adequate supervision and diversional programs to prevent unsafe wandering while maintaining the least restrictive environment for those at risk for elopement.</p>		