STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455963	A. Building B. Wing	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carthage Healthcare Center	701 S Market St Carthage, TX 75633

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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews 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 1 of 8 residents (Resident #1) reviewed for accident hazards and supervision.The facility failed to supervise and put measures in place to keep Resident #1 from eloping on 6/13/25.The facility failed to complete Resident #1's quarterly elopement risk assessment due after 12/27/25. Resident #1's elopement risk assessment was not completed until 06/13/25, after she had eloped from the facility.The noncompliance was identified as PNC. The IJ began on 06/13/25 and ended on 06/17/25. The facility had corrected the noncompliance before the survey began. These failures could place the residents at risk for serious injury, serious harm, serious impairment, or death. Findings included:Record review of Resident #1's face sheet, undated, indicated Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses including schizophrenia (is a serious mental health condition that affects how people think, feel and behave), bipolar disorder (is a mental health condition that causes extreme shifts in mood, energy, and activity levels, impacting a person's ability to carry out daily tasks), generalized anxiety disorder (is a mental health condition characterized by excessive, uncontrollable, and often irrational worry about everyday things), intermittent explosive disorder (is a mental health condition characterized by sudden, impulsive, and disproportionate outbursts of anger or violence), autistic disorder (is a condition related to brain development that affects how people see others and socialize with them), tremor, and right ear hearing loss. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was usually understood and usually had the ability to understand others. Resident #1 had adequate hearing, clear speech, and impaired vision with corrective lenses. Resident #1 had a BIMS score of 09 which indicated moderate cognitive impairment. Resident #1 did not display wandering behaviors. Resident #1 used a walker and wheelchair as mobility devices. Resident #1 required supervision to walk 10 feet and 50 feet with two turns. Resident #1 required substantial assistance to walk 150 feet. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was usually understood and usually had the ability to understand others. Resident #1 had adequate hearing, clear speech, and impaired vision with corrective lenses. Resident #1 had a BIMS score of 11 which indicated moderate cognitive impairment. Resident #1 displayed wandering behaviors 1 to 3 days during the assessment period. Resident #1 used a walker and wheelchair as mobility devices. Resident #1 required supervision to walk 10 feet and 50 feet with two turns. Resident #1 required partial assistance to walk 150 feet. Record review of Resident #1's care plan dated 10/20/24, edited on 06/29/25 indicated:*Resident #1 had intermittent explosive disorder, Schizophrenia, bipolar disorder and anxiety which could affect her mood. Interventions included encourage to report any concerns or needs, assess, monitor, and document mood, and reassure and listen to concerns. *Resident #1 had cognitive deficits and mental disability with childlike responses, poor cognition, delayed response, concentration and attention difficulties, Autism, and speech impediment. Resident #1 had hearing loss in her right ear. Resident #1 had risk for communication deficits. Interventions included allow time when speaking to process thoughts and speck directly to resident in a clear voice facing her. Record review of Resident #1's care plan dated 06/13/25, edited on 06/29/25 indicated:*Resident #1 was at risk for elopement as evidenced by attempt to leave the facility on 06/12/25. Interventions included frequent monitoring and checks throughout the night to ensure safety and roam bracelet will be always worn.*Resident #1 was at risk for wandering due to attempt to exit seek. Resident #1 wore a roam alert bracelet. Intervention included an elopement assessment done on admission, as needed, and with significant change of condition and staff will monitor and report change in exit seeking behaviors. Record review of Resident #1's assessment for risk of elopement dated 12/27/24, completed by LVN A, indicated Resident #1 was not at risk for elopement at this time. Record review of Resident #1's medical records did not reflect an assessment for risk for elopement due 90 days or quarterly from the 12/27/24 assessment for risk of elopement. Record review of Resident #1's assessment for risk of elopement dated 6/13/25, completed by ADON G, indicated Resident #1 was likely at risk for elopement due to resident being ambulatory yet cognitively impaired with poor decision-making skills. Resident #1 was at risk for elopement. Resident #1 had the following intervention implemented of Wander guard (is bracelet with triggering alarms and locking monitored doors to prevent wander-prone residents from leaving unattended) with informed