STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675001	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands	125 Inspiration Blvd Eastland, TX 76448

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 Based on observation, interview, and record review the facility failed to protect the resident's right to be free from neglect for 2 of 14 residents (Resident #10 and Resident #11) reviewed for neglect. The facility failed to ensure Resident #10 was secured with a seatbelt when being transported in the facility van to an appointment in another town approximately 47.5 miles one way on 03/26/2025. Resident #10 fell out of his wheelchair onto the floor of the facility van. The facility failed to ensure Resident #11 was secured with a seatbelt when being transported in the facility van to an appointment in another town approximately 47.5 miles one way on 03/18/2025. An Immediate Jeopardy (IJ) was identified on 03/31/2025. While the IJ was lowered on 04/02/2025 at 9:23 AM, the facility remained out of compliance at a severity level of no actual harm potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures placed residents at risk of injury due to not being supervised and placed them at risk of serious bodily harm, physical impairment, or death. Findings include: Resident #10 Record review of Resident #10's face sheet revealed an [AGE] year-old male admitted on [DATE] with the following diagnosis Diabetes Mellitus type II, Flaccid hemiplegia (compete paralysis, lack of muscle tone) Left side Chronic Obstructive Pulmonary Disease (lung disease). Record review of Resident #10's Quarterly MDS dated [DATE] revealed a BIMS score of 12 meaning moderately impaired cognition. Section G Functional status: Resident #10 required extensive assist with bed mobility, transfers, and toileting. Record review of Resident #10's Care Plan dated 02/18/2025 revealed: Resident had decreased functional limitation in ROM (range of motion) to left side. Decreased mobility to left side. Approach: Ensure staff aware of resident's mobility/ADL (activities of daily living) impairments. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #11 Record review of Resident #11's face sheet revealed a [AGE] year-old female who was admitted [DATE] with the following diagnosis Cerebral Infarction (condition where blood flow to brain is blocked), Bilateral above the knee amputation (removal of both legs above the knee), Diabetes Mellitus type II, Congestive Heart Failure (heart disease), chronic kidney disease (kidney damage) End Stage Renal Disease (dialysis). Record review of Resident #11's Quarterly MDS dated [DATE] revealed: Section C Cognitive Status: Resident had a BIMS of 15 (Intact Cognition). Section GG-Functional Abilities GG0115 Functional Limitation in Range of Motion lower extremity impairment on both sides. Car transfer-substantial/maximal assistance. During an observation and interview on 03/27/2025 at 02:15 PM, Resident #10 was lying in bed awake, unable to move left arm. Resident #10 stated he went in the facility's van with Transport Aide F as driver to dental appointment in another town. Resident #10 stated his wheelchair was secured in the van, but he did not have on seatbelt or anything to secure him in his wheelchair. Resident stated he asked Transport Aide F to put the seatbelt on and Transport Aide F told him she did not like the seatbelt, so she did not put it on him for the drive to appointment in another town approximately 47.8 miles one way. the facility. Resident #10 stated it made him feel unsafe. Resident stated they were on interstate and a truck was ahead of them and Transport Aide F had to slam on the brakes, and Resident #10 came out of wheelchair and landed on the floor with my right leg up under the dash of the van. Resident #10 stated he asked Transport Aide F to pull over and she told him he couldn't pull over until there was an exit. Resident stated this happened approximately 30 miles from #10 stated he had to lay on the floor of the van for about 30 minutes until they got back to the facility. Resident #10 stated when they got back to the facility it took 4 people to get him out of the van and into a wheelchair. Resident stated Transport Aide F knew that he needed the seat belt but did not put it on him. During an interview on 03/28/2025 at 02:45 PM, the ADMN stated Transport Aide F was hired on 08/15/2024 and had 2 weeks training before starting van driver position. Transport Aide F initial training was on 11/01/2024. ADMN stated Transport Aide F had been checked off on competency of use of seat belts and securing wheelchairs in van again on 03/25/2025 by MM. ADMN stated Resident #11 was identified through the complaint process on 03/25/2025 of not being buckled in with seat belt when being transported. ADMN stated in-service consisted of each van driver providing a return demonstration on use of seatbelts in van for residents in a wheelchair. During an interview on 03/28/2025 at 04:00 PM, MM stated he trained Transport Aide F on 08/15/2024 by showing her how to secure a resident in a wheelchair in the facility van. MM stated Transport Aide F performed return demonstration several times on the use of wheelchair tie downs and use of seat belt. MM stated Transport aide-F had not reported any problems with seatbelt in van. MM stated Transport Aide F completed the refresher course on 03/25/2025 that included how to strap the wheelchair down with ties, and how to safely buckle residents with seat belt, and she demonstrated how to secure wheelchair in the van and to safely buckle a resident with a seat belt. MM stated Transport Aide F was instructed if the van is not safe do not drive, stop, and call 911 and notify ADMN and DON. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/28/2025 at 02:30 PM, Transport Aide F stated she transported Resident #10 in facility van to dental appointment in another town, on 03/26/2025 at 08:00 AM Transport Aide F stated there was construction on the interstate and she had to slam on her brakes to avoid hitting a vehicle in front of the van. Transport Aide F stated when she slammed on the brakes, Resident #10 was thrown out of his wheelchair onto the floor of the van. Transport Aide F stated she got off the interstate to see if Resident #10 was hurt and if he wanted to get back in his wheelchair. Transport Aide F stated Resident #10 told her he did not want to get back up into the wheelchair. Transport Aide F stated she did not secure Resident #10 with a seatbelt because she was not sure how to secure a resident. Transport Aide F stated she did not feel she was properly trained in how to use a seatbelt. Transport Aide F stated Resident #10's wheelchair was secure to van floor properly. Transport Aide F stated she thought Resident #10 was secure in the van with wheelchair being secure to the floor. Transport Aide F stated she was suspended until today and will not be driving the van anymore. During an interview on 03/28/2025 at 02:50 PM, Resident #11 stated on 03/18/2025 while being transported in facility van to appointment in another town, Resident #11 asked Transport Aide F to put on her seatbelt. Resident #11 stated Transport Aide F told her seatbelt did not work. Resident #11 stated Transport Aide F put on brakes, and Resident #11 had to put her hands on the back of the seat in front of her to keep from falling out of wheelchair. Resident #11 stated Transport Aide F made her feel unsafe in the van and would not go in the van if Transport Aide F was driving. During a follow-up interview on 03/28/2025 at 04:00 PM, MM stated he trained Transport Aide F by showing her how to secure a resident in a wheelchair in facility van. Transport Aide F performed return demonstration several times. MM stated Transport aide-F did not report any problems with seatbelt in van. MM stated a refresher course was done on 03/25/2025 on how to strap the wheelchair down with ties, and how to safely buckle residents in a wheelchair with seat belt, if van not safe do not drive stop and call 911 and notify ADMNIN and DON. During a follow-up interview on 03/29/2025 at 01:05 PM, Transport Aide F stated she forgot to put the seatbelt on Resident #11 on 03/18/2025 during transport to appointment. Transport Aide -F stated on 03/25/2025 refresher course, she did not buckle the seat belt was only shown how it works. Transport Aide -F stated she remembered signing the in-service sheet dated 03/25/2025 for use of seatbelt. Transport Aide F stated there was construction on the interstate and she slammed on the brakes to not wreck. Transport Aide F stated Resident #10 slid out of wheelchair and Resident #10's left leg went under dashboard. Transport Aide F stated she pulled off the interstate at the next exit. Transport Aide F stated she asked Resident #10 if he was okay and if he wanted to get back into his wheelchair. Transport Aide F stated Resident #10 told her to just drive slowly and get him back to the facility. Transport Aide-F stated Resident #10 was just lying on floor of van and not saying anything about hurting. Transport Aide-F stated she did not call the ADMN because she did not feel she need to call since they were only 20-25 minutes away from the facility. Transport Aide-F stated she was unsure of where construction was on interstate. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/30/2025 at 11:13 AM, the ADMN stated there were no manufacture instructions in the van that she was aware of. The ADMN stated she thought the employee chose not to follow training and safety precautions. The ADMN stated she reeducated staff on 03/27/2025 and suspended Transport Aide F and took the facility van out of service for wheelchair transports. ADMN stated facility van was scheduled for safety inspection in another town on Friday 03/28/2025 for safety inspection of seatbelts. The ADMN stated the safety inspection determined the seat belt and the wheelchair tie downs were functioning properly, but it was recommended to upgrade the system due to it being old and antiquated. The ADMN stated the facility chose to not use the facility van for wheelchair transports. The ADMN stated what led to the failure of the neglect was Transport Aide F to follow the policy and procedures. The ADMN stated the facility would prevent further neglect by conducting resident council meetings, making rounds with residents for safe surveys, observe resident care and feedback from the staff and the residents. The ADMN stated only when a resident complained, was the issue addressed. The ADMN stated competencies were conducted on hire, annually and as needed with compliance. The ADMN stated MM inspected the van weekly and reported any negative findings. The ADMN stated she would expect staff to follow procedures and policies. Record review of facility policy titled: Van Driver Orientation Policy & Procedure, not dated revealed: Policy: Each employe who is designated to drive the facility van will receive adequate orientation and training to assure the safety of all passengers . 4. The designated trainer will instruct and review with the employee procedures to follow in case of an emergency and/or accident. The instruction shall include at a minimum: the facility phone number to contact, Administrators' cell phone number to contact, immediately call 911 in case of injury to any van passenger .to contact local police in caser of an accident .thoroughly check all passengers to assure well-being and seatbelts are secure 7 Once the steps are read and the designated trainer must instruct and observe return demonstration by employee n the correct procedure for safely securing a resident in a wheelchair and an ambulatory resident using the safety belts provided in the van. The employee must demonstrate how to safely apply and tighten the safety belts to prevent a wheelchair from rolling or tilting during transport and how to secure the safety belt around the resident to prevent injury Review of facility's policy titled, Identifying Types of Abuse, dated revised September 2022 revealed: As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents 1. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 2. Neglect occurs when the facility is aware of, or should have been aware of, goods, or services that a resident requires but the facility fails to provide them, and this has resulted in (or may result in) physical harm, pain, mental anguish, or emotional distress. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Do you know who the Ombudsman is ? 6. Do you feel safe when transported by facility staff? Findings: Resident #10 and # 11 both reported issues with same driver not following training/using seat belts to secure resident. The other 5 residents did not report safety issues, just that the van was old and rundown. Staff did share that the center has a new van on order to replace the current van. On 3/25/2025 the van driver was retrained on facility safety procedures for strapping residents into the wheelchair using the wheelchair tie downs and seatbelts by another staff member. The NHA Nursing Home Administrator observed the retraining of the van driver, by the more senior staff member with experience driving the van. The van was removed from service for transporting residents in wheelchairs on 3/26/2025. The van will not be put back in service until the complete restraint system including seatbelts for wheelchairs is replaced. The facility has purchased a new van with delivery expected this week. Residents requiring wheelchair transport will be completed by sister facilities until all staff who will drive are checked off for operations of the lift, the wheelchair tie downs and seatbelts of the new van. Administrator, Surveyor and 2 facility approved drivers observed sister facility driver demonstrate the wheelchair tie downs and seat belting prior to transporting our resident on Monday 3/31/2025. One of our van drivers accompanied the resident and the driver on the appointment. The Administrator reviewed the van driver's competencies that were completed on the vehicle. Residents will not be transported in the existing van in a wheelchair until after the restraint system is updated and all drivers are checked off on securing the wheelchair with tie downs and seatbelts system for the residents. on 4/1/25 Both van drivers have been in serviced not to use the wheelchair van until the system for securing wheelchairs is replaced with new system and competencies with return demonstration are completed by the Nursing Home Administrator/Designee. On 3/26/2025 The van driver was suspended pending investigation. The van was removed from service in transporting wheelchairs on 3/26/2025 at 11am. Van was inspected on 3/28/2025 by a company that specializes in wheelchair transport vehicles. The technician stated to the Maintenance Supervisor the system is functioning, but old and needed to be updated. The NHA Nursing Home Administrator called to follow up the inspection report, was told there was a missing part, but was unable to determine what was missing since he was not aware of what system was installed in the van. The Administrator went back out to the van along with the more senior staff member with experience driving the van and could not find anywhere else a missing part would be mounted in the floor or sides of the van. There is a seatbelt part in the floor that the technician said was missing, but during the inspection by the NHA Nursing Home Administrator and the more senior staff person with experience driving the van the part is in the floor to connect the seatbelt. There is not an inspection report. NHA Nursing Home Administrator did call and email multiple times to request the report. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/31/2025 The NHA Nursing Home Administrator/Designee in-serviced all staff on the state provider letter PL 2024-14 Abuse Neglect Exploitation, Misappropriation of resident property and other incidents. The NHA Administrator/Designee chose to use another format to Inservice instead of the facility's policy and procedures on Abuse, Neglect, Exploitation and Misappropriation Program and Identifying Types of Abuse as staff were just in serviced on 3/20/2025 and 3/26/2025. All staff including new hires and agency, will be required to complete the in-service prior to starting their next scheduled shift. On 3/31/2025 NHA Nursing Home Administrator/ Designee In service all staff that drive the van on safety and emergency procedures with post test. If staff fail the post test they will be retrained again and tested again. Staff will not be allowed to operate the facility van until they have successfully passed the post test. On 3/31/2025 NHA Nursing Home Administrator /Designee performed competencies and return demonstration on emergency procedures, operating the wheelchair lift, test Driver on driving and reviewing you tube video for strapping the wheelchair and buckling the person in the wheelchair on all transport staff. Staff will be suspended from driving until competencies are passed. Competencies with return demonstration will be completed on hire, annually, and PRN. On 3/27/2025 NHA Nursing Home Administrator and Regional Nurse Consultant reviewed the Van Driver Orientation List and added instructions for emergency procedures to include procedures for if a resident falls out of seat or chair to pull over, call 911, notify NHA Nursing Home Administrator. On 3/31/2025 NHA Nursing Home Administrator/Designee will conduct audits with observation to be completed for proper securement of wheelchair and seatbelt use weekly times four weeks, then weekly times two weeks and PRN there after. 3/31/25 NHA Nursing Home Administrator /Designee will interview residents who are transported by facility staff. Residents will be asked the following questions: 1 Were you buckled in and wheelchair secured? 2. Did the driver follow posted speed limits and other traffic signs? 3. Did the driver use cell phone while driving? 4. D d you feel safe while being transported? 5. Do you have any other concerns? Interviews will be conducted with residents who are transported by the center staff weekly for four weeks, then weekly for two weeks and PRN thereafter. On 3/27/2025 Ad-Hoc QAPI Held with Medical Director, NHA Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant to review the alleged deficiency, policy and procedure and the plan of removal of immediacy. Ad-HOC QAPI repeated on 3/31/2025. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The NHA Nursing Home Administrator will be responsible for ensuring the plan is completed on 3/31/2025. The RDO/Designee will provide oversight by observation and record reviews to the of NHA Nursing Home Administrator to ensure that the items on the plan of removal are reviewed and completed on 3/31/2025. The RDO/ Designee will continue monitoring weekly for four weeks, then monthly for two months then as needed. Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interviews, and record review from 04/01/2025 at 4:24 PM to 09:23 AM as follows: During an interview on 04/02/2025 at 05:34 AM, NA T stated she/he had in-service on neglect on 04/01/2025 by DON. NA T stated neglect was not changing a resident, not answering call lights, and not keeping resident safe. NA T stated she or he would report any suspected neglect to charge nurse and ADM. During an interview on 04/02/2025 at 05:38 AM, LVN K stated she had in-service on neglect on 04/01/2025 by DON. LVN K stated neglect was the failure to provide services to resident like not giving them their medications, not keeping them clean, not answering call lights and not keeping them safe. During an interview on 04/02/2025 at 05:40 AM, LVN V stated neglect was failure to provide resident with services such as medications, providing fluids, keeping them clean, helping them when asked for help. LVN V stated she would report neglect to ADM. LVN V stated she had in-service on neglect on 04/01/2025 by DON During an interview on 04/02/2025 at 05:42 AM, NA L stated he had in-service on neglect on 04/01/2025 by DON. NA L stated neglect was leaving a resident in soiled diaper for a long time, not feeding a resident, not answering call lights, not keeping them safe. NA L stated he would report to charge nurse and ADM. During an interview on 04/02/2025 at 05:50 AM, CNA A stated had in-service on neglect. CNA A stated neglect was leaving a resident unattended, not keeping them clean, leaving them in bed for hours and not checking on them. CNA stated she would report neglect to charge nurse and ADM. During an interview on 04/02/2025 at 05:55 AM, CNA stated she had in-service on Neglect 04/01/2025 by DON. CNA W stated neglect was not changing a resident when they were wet, not giving them something to drink, not keeping them safe. CNA W stated she would report neglect to charge nurse and ADM. During an interview on 04/02/2025 at 06:05 AM, LVN Y stated she had an in-service on neglect on 04/01/2025 By DON. LVN Y stated neglect was the failure to provide care such as not keeping residents safe. She stated she would report neglect to ADM. During an interview on 04/02/2025 at 06:08 AM, LVN P stated she had in-service on Neglect on 04/01/2025 by DON. LVN P stated neglect was the failure to provide care to residents. LVN P stated the failure could be not assisting resident to eat, not providing incontinent care. LVN P stated she would report any neglect to ADM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on o4/02/2025 at 08:40 AM of facility safe assessment conducted on 03/26/2025 of Resident #11, Resident #12, Resident #13, and Resident #14 safe survey interviews conducted by ADM revealed above residents did not feel safe when transported by facility van. The residents' stated van is not in good condition. Record review on 04/02/2025 at 08:42 AM of facility safe assessment conducted on 03/27/2025 for Resident #10 revealed Resident #10 did not feel safe when transported by facility staff due to staff did not follow training. During a record review on 04/02/2025 at 08:45 AM of Transport Aide F facility counseling dated 03/26/2025 Transport Aide F was suspended pending investigation of van incident. An Immediate Jeopardy was identified on 03/31/2025. While the Immediate Jeopardy was removed on 04/02/2025 at 09:23 AM, the facility remained out of compliance at a level of no actual harm with a potential for more than minimal harm and a scope of pattern, due to the facility monitoring the effectiveness of their Plan of Removal. The ADMN, the DON, and the RRN were informed of the Immediate Jeopardy was removed on 04/02/2025 at 9:23 AM.

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The Woodlands	125 Inspiration Blvd Eastland, TX 76448

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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 - Some	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** 44558 Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 3 of 14 (Resident #3, Resident #10 and Resident #11) residents reviewed for supervision. 1. The facility failed to provide supervision for Resident #3, who was care planned for wandering in unsafe places, to prevent him from eloping from the facility on 03/21/2025. The facility was unaware Resident #3 had exited the facility, through his unlocked window in the secure unit. The facility failed to provide adequate supervision in secured locked unit to prevent elopement on 12/05/2024 and 03/23/2025. An Immediate Jeopardy (IJ) was identified on 03/21/2025. While the IJ was lowered on 03/28/2025 at 4:45 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. 2. The facility failed to ensure Resident #10, and Resident #11 were safely secured in the facility van while being transported to and from the facility. An Immediate Jeopardy (IJ) was identified on 03/31/2025. While the IJ was lowered on 04/02/2025 at 9:23 AM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. These failures placed residents at risk of injury due to not being supervised and placed them at risk of serious bodily harm, physical impairment, or death. Findings include: 1. Record review of Resident # 3's face sheet dated 03/24/2025 revealed a [AGE] year-old female admitted on [DATE] with a readmission on 02/19/2025 with the following diagnoses cardiac issues, seizures, and traumatic brain injury. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed: Section C - Cognitive Patterns Resident #3 had a BIMS of 14, meaning cognitively intact. Section GG Mobility Devices Resident #3 required the use of a walker. Record review of Resident #3's Care Plan updated on 03/21/2025 revealed: Problem: start date 10/09/2024 I am on the memory care unit due to exit seeking behaviors. On 3/21/25 had actual Elopement through bedroom window-High Risk 20. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Goal: Resident will remain free from injury related to exit seeking/elopement attempts through next quarter. Approach: Start Date 03/21/2025 Consider Medication Review if behaviors continue or escalate; Start Date- 03/21/2025 Consider psych consult with increase in behaviors; Start Date- 03/21/2025 Ensure all basic needs are met when resident. becomes anxious or aggressive. Offer toileting, snack, fluids, comfort. Etc.; Start Date- 12/05/2024 Resident must be accompanied by staff while in courtyard. Start Date- 10/09/2024 Assess/ record/ report to MD risk factors for potential elopement such as: wandering, repeated requests to leave facility, attempts to leave facility. Start Date- 10/09/2024 Check doors & windows for security and for proper functioning and placement per facility protocol. Start Date-10/09/2024 Develop and activities program to divert. attention and meet needs for social, cognitive stimulation; Start Date- 10/09/2024 Discuss with resident/ family risks of elopement. and wandering; Start Date- 10/09/2024 If resident is missing from facility, follow elopement protocol, notify MD and family. immediately, and document; Start Date- 10/09/2024 Placement on secure unit for high risk for elopement; Start Date: 10/09/2024. Supervise closely and make regular compliance rounds whenever resident is in room. Record review of Resident #3's physician orders revealed Start date of 10/09/2024 Admit to facility secure unit. Record review of Resident #3's progress notes revealed: Date 10/24/2024 at 4:52 PM documented by LVN C creating a map of the exits of the Secure Unit, when asked the Resident did not respond and only nodded to agree with the co-conspirators statement of getting out of here. This Nurse explained to Resident that his placement here was agreed between his mother and himself to promote independence in a safe environment. Resident stated, I don't care, I can leave if i want to. Further education given on importance of remaining safe as well as dangers surrounding facility. Resident was not agreeable to education and walked away. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date: 12/05/2024 at 15:42 PM documented by LVN C Resident found by Staff on ALF Patio attempting to gain entry to ALF. ALF Patio is separated from Secure Unit Courtyard by 4ft locked fence. [NAME] located pushed against fence beside bush. Resident states he hopped the fence to go to [nearby town]. Resident story changed multiple times and includes wanting to sit somewhere else and wanting fresh air. Resident assessed for injury, no skin impairments or bruising noted to any part of body, Resident denies pain. PCP notified, attempted to notify Mother voice mail not available. Resident previously given freedom to come and go From Secure Unit Courtyard, at this time Staff must be present in area for Resident to venture outdoors to prevent injury from attempt to leave area and to prevent Resident eloping from facility. Date 12/10/2024 at 9:30 PM documented by LVN K Resident walking around in secure unit with walker . States, I need you to let me out of here. Resident continues to exit seek daily. All care was witnessed by staff. Date 12/12/2024 at 2:30 AM documented by LVN O res up ambulating throughout night on unit with and at times without his walker, when amb without walker res has unsteady gait. becomes upset when staff encourage use of walker and remind res staff do not wish him to fall again with potential injuries a possibilities. Also res asked CNA to open secure unit doors, while standing at the front of unit by main doors. this writer entered secure unit, res attempted to grab doors as they closed but was unable and almost fell attempting to. reminded res doors must remain closed and locked, he started yelling loudly and repeatedly, bull shit. when asked to have consideration for others who are sleeping he yells, I don't fucking care all attempts to calm res unsuccessful. res went back to his room on his own. has come out since 3 times and stood at front of unit doors pushing on handle of doors until alarm sounds, when staff attempted to redirect him from this behavior he again starts to yell and whenever staff opened door of unit to turn off or reset alarm he again grabs at door trying to walk through door with staff in doorway. after these attempts he says I give up and I'm walking out of here tomorrow. Date 12/12/2024 at 7:10 PM documented by LVN P Rsd held locked double doors of memory care unit until they opened. Attempted to exit and became angry and combative when staff attempted to intervene. CNA called out for assistance and staff immediately assisted. The rsd appeared very angry stating, I am leaving this place. I am going home to [NAME]! I'm going to walk!. Rsd was given emotional support by staff and the situation de-escalated. The rsd walked to his room in an angry manner yelling profanities. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date 12/13/2024 at 9:30 AM documented by LVN Q resident has been very restlessness and uncooperative with staff his attempt to leave the unit with holding the hand bars down for the full 15 seconds and then the alarms were alarming, and the staff had to retrieve resident before he could leave the unit unattended that is when he became increased restlessness with agitation and aggressively pacing with rollator walker staff was unsuccessful with keeping him from exiting the unit while visitors were coming into unit and staff then was able to get to him within 3 feet of him exiting the unit, this nurse was summoned to unit STAT, on arrival this nurse was able to calm him down and redirect him into sitting in the HR Desk where this nurse then called his mother to advise her of the above uncooperativeness and agitation then this nurse asked if she would attempt to talk with him to calm him down even more , he then was on the phone talking with his mother demanding her to come get him and take him home, she spoke with him approximately 10 minutes then he let this nurse speak with her again this nurse was advised that the mother was unable to come today due to she has appointments and obligations already in motion and she was unable to change them on short notice she did declare that she would be here this weekend sometime to visit him and she felt that would help him for this behavioral episode, that is when the resident agreed to go back into the unit without behaviors noted. Date 12/13/2024 at 12:42 PM documented by LVN Q Resident is at the unit doors attempting to elope and exit seeking is in high risk at present time the unit is where he is with a staff at all times due to his quick and exit abilities are placing himself in harm's way this nurse has made a call into the office of FNP at present time this nurse is on hold in que for the answering service, staff was instructed to stay with resident to help protect him from being able to exit while the staff was assisting other residents. Date 12/14/2025 at 2:30 PM documented by LVN R kitchen worker came through door that leads from kitchen into memory care kitchen. Res grabbed door and would not let go. CNA stood between res and door and called this nurse. This nurse went to memory care, finally convinced res to go outside into courtyard. Res and nurse sat on bench and talked for a while then went back inside to call his mother. Res talked to his mother for approx 15-20 min then went back to memory care. Date 12/29/2024 at 10:16 AM documented by LVN Q noted at present time resident has been with pacing and becoming agitated about wanting to go home, this nurse has attempted to redirect resident with having him have the broom and dustpan so he can sweep to redirect his focus on wanting to leave, noted has worked at this point on his redirection. Date 12/30/2024 at 12:40 PM documented by LVN P CNA reported to this nurse that the resident continues to show unprovoked aggressive behavior toward staff members. The rsd became angry this AM when the breakfast trays arrived when he wasn't immediately served before others and began cussing the CNA and banging on the table. The rsd has a hx of frequent angry outbursts with use of profanity and tendencies to use physical force. The rsd is actively exit seeking and has damaged two exit doors and his window facing the courtyard in attempts to escape. The rsd is alert and is aware this behavior is not appropriate and verbalizes that he knows it is wrong. However, the rsd exhibits ST memory deficits and appears not to remember the behaviors or appears confused at times when questioned. Date 01/02/2025 at 3:30 PM documented by LVN C Resident attempted to exit memory care Secured Unit while doors were open. Resident was immediately stopped by nearby Staff. Resident attempted to hit with walker, hit CNA with closed fist and proceeded to yelling and cuss at those stopping him. Resident would not be redirected from attempting to exit memory care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date 02/06/2025 at 5:28 AM Documented by LVN O res went to x 2 cnas and nurse on this hall telling staff to open the doors and let him out. Res also went to all exits multiple times since 0400 of unit pushing egress on doors causing alarms to go off at these doors and not easily redirected, staff members on both sides of exit doors until res stopped pushing at doors, he also amb into doorway of other res rooms and not easily redirected. When encouraged to continue to rest through to morning meal went back to his room but yelled at this writer once let me out loudly then entered his own room. Date 02/07/2025 at 1:37 PM documented by LVN C Resident has continued previous behavior of pushing/pull on secured locked doors and pacing. Date 02/09/2025 at 2:59 PM documented by LVN C This Nurse could intervene Resident began screaming at that person This is my house I can go wherever the f**k I want. This Nurse stood between the two and prevented Resident from entering further into the room. Resident attempted to punch This Nurse, This Nurse leaned out of the way and prevented injury to either party. DON notified and instructed This Nurse to call Residents mother and have them talk on the phone. Residents Mother stated to This Nurse I don't know what to do about it She spoke with Resident via phone, Resident finally left the other persons room. After the end of the phone call Resident began pacing and trying to exit secure doors. Date 02/12/2025 at 5:01 AM documented by LVN O wanting staff to let him out, becomes angry when staff not able to, pushing at doors and setting off alarms on doors, only then does he back off the doors, Date 02/22/2025 at 4:50 PM documented by LVN C Resident has been exit seeking this shift. Pacing unit from door to door attempting to pry them open. Resident has been attempting to push past staff when doors are open. Date 02/26/2025 at 5:59 AM documented by LVN O res had behaviors through this night shift, cursing at staff when he would demand to be let out of secure unit or being given the code to the doors and staff explained that were unable to do so, res pushing and pulling at all exit doors all throughout night shift, res multiple times pulling at doors hard and almost falling backwards, staff steading res with their hands trying to keep res safe from falling and he would yell don't touch me and attempt to swing at staff. staff would encourage res not to do so for his safety. he would curse at staff and continue doing so despite encouragement. res caused alarms to go off numerous times pushing at doors. Date 02/27/2025 at 5:29 AM documented by LVN K resident continues with negative mood, continues to exit seek throughout the shift, redirected away from doors, requires constant monitoring, denies any pain, stated, are you going to let me out of here to get my pick up and go to [Nearby City]? This nurse reassured him that she would not be assisting him in leaving facility. Date 03/02/2025 at 4:34 documented by LVN O res up walking without walker this shift and continues to ask staff and demand staff let him out of unit, continues to push at doors to attempt to exit, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date 03/03/2025 at 5:47 AM documented by LVN O res continues to attempt to leave secure unit and pushes at doors, earlier in shift got through door at end of unit that leads to AL dining room, after pushing door for 15 seconds setting off egress and releasing door, (as safety required sign on door states to do) required 3 staff members to get res to back into unit safely and reset door, res also attempted same maneuver on other dining room door that leads to outside at front of building but staff were able to get between res and door and keep him in building and safe. Date 03/04/2025 at 2:06 PM documented by SW Writer Contacted resident's mother, [insert name] to discuss recent. behaviors of pushing on the exit door to the parking lot for 15 plus seconds until the door open and then going outside to a parking lot which is next a four-lane busy highway. Resident's mother is in agreement that resident needs to be in a unit that has a fence between the road/street or no assess to the street for his safety. Date 03/07/2024 at 4:44 AM documented by LVN O res continues exit seeking this shift and pushing at doors, cursing at staff when unable to let him out of unit, res gait is unsteady when not using walker, Date 03/14/2025 at 3:51 AM documented by LVN K states, i wanna go home. Date 03/21/2025 at 2:47 PM documented by LVN C Resident displaying exit seeking behavior: pushing on doors, attempting to push past Staff to Exit . will continue to monitor for exit seeking behaviors. Date 03/21/2025 at 8:55 PM documented by LVN S at 19:59 code white was called after being unable to locate resident and finding his window open. This nurse located resident in front of [City name] Dialysis center and accompanied resident safely back to facility. Upon assessment no injuries noted to rt, rt denies pain . Rt stated I don't want to be her anymore! I want to leave RT placed on Q 15 minute checks for 24 hours. RT RP [RP name] called, situation explained stating she understands situation and has no further questions or complaints. PCP faxed. All windows in facility checked, maintenance [name] coming to ensure windows are in compliance with regulations. Rt moved to different room, resting in bed peacefully. Date 03/21/2025 at 9:51 PM documented by DON Res smiling and states I want to go home. I'm going home. Discussed risks of leaving facility against medical advice and risks associated with elopement. Verbalizes understanding and states I know, but I don't care. Date 03/22/2025 at 5:48 AM documented by LVN K Resident awake, sitting on side of bed . resident alert and oriented, talking with staff, stating he will bust out again. Continue to monitor closely Date 03/23/2025 at 4:52 PM documented by LVN C Resident exit seeking this shift. Eloped from Memory Care unit into ALF and was exiting ALF dining room door that leads to highway. Resident stopped outside door and escorted back to Memory Care. No injuries noted, Resident denies pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date 03/24/2025 at 1:07 PM documented by DON Clarification to note on 06/23/25 at 1652: Spoke with on duty memory care CNA on date of entry. CNA states res approached door in memory care dining room. Resident pushed on door, causing door alarm to sound. CNA immediately recognized and responded to alarm. CNA reports res was standing outside door of memory care dining room next to building. Res immediately redirected resident back through memory care dining room door without difficulty. Staff will perform 1 on 1 resident observation at this time until further placement arrangements can be made. During an observation on 03/21/2025 at 7:10 PM, Resident #3 was observed sitting at desk with CNA A. CNA A said she was the only staff that was working on the secured unit. CNA A stated if something was to happen, she would have to leave the residents to make a phone call for help or leave the unit to call for help from the other unit. During an observation on 03/21/2025 at 8:15pm, there was no lock on Resident #3's bedroom window and two of the dining room windows facing the street did not have a lock. Resident #3 had been moved to another room with an interior window that had a lock and faced the gated courtyard. During an interview on 03/24/2025 at 2:40 PM, LVN C stated she was working on 03/23/2025 but was not on the secure unit when she heard the alarm go off. LVN C stated when she entered the secure unit, she saw CNA E standing at the door (that exited out of the secure unit dining area into the parking lot) attempting to turn the door alarm off. LVN C stated she exited thru the secure door that entered the ALF and noticed the door exiting the ALF dining room (north side of building facing the major highway) was open. LVN C stated she located Resident #3 outside of the ALF door with his walker. During an interview on 03/25/2025 at 10:35 AM, the DON stated Resident #3 was placed on 15-minute safety rounds checks after his elopement on 03/21/2025 for 24 hours. Staff was responsible to ensure Resident was safe and not trying to exit seek. The resident was then placed on 1:1 supervision on 03/24/2025 at 4:54pm until he was to be transferred to another facility. The DON stated the ADMN and MM were responsible to ensure the locks were placed on window. The DON stated not having locks on the windows led to failure of Resident #3 being able to exit his window. During an interview on 3/25/25, the Administrator stated when Resident #3 returned from behavioral hospital on 02/04/2025, she asked the maintenance director to make sure that all the windows hand locks in the secure unit, because there were several that did not have locks. The ADMN stated she did not go back and follow up to ensure they were done. The ADMN stated her expectation was that MM had put the locks in the windows. The ADMN stated what led to failure was that MM did not put locks on the windows and she failed to verify the windows had locks. The ADMN stared she had not reported the incident on March 23rd because even though Resident # 3 was able to exit the secure unit, he did not leave the property. During an interview on 03/25/2025 at 1:15 PM the MD stated he had provided care for Resident #3. The MD stated due to Resident #3's traumatic brain injury he was not capable of making decisions on his own and was not safe to be out of facility on his own. The MD stated the facility was on a major highway and if Resident #3 were to have gotten out of the facility, he could have had the potential of being stuck by a motor vehicle. The MD stated having only one staff on the secure unit during a shift was not sufficient staff to supervise all the resident's needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility policy titled, Wandering and Elopements dated 2001 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. If identified as at risk for wandering, elopement, or other safety issues, the residents' care plan will include strategies and interventions to maintain the residents' safety. This was determined to be an Immediate Jeopardy (IJ) on 03/21/2025 at 4:31 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 03/26/2025 at 12:30 PM. Record review of Plan of Removal accepted on 03/27/2025 at 5:17 PM reflected the following: FACILITY: [Facility Name] Facility ID Number: 110493 SURVEY TYPE: Complaint Survey SURVEY DATE: 3/26/2025 Plan for REMOVAL Plan to remove immediate jeopardy. The facility allegedly failed to ensure a resident with a known history exit seeking and elopement received with adequate supervision in a secured locked unit to prevent elopement. F689 On 3/26/2025 the Administrator notified Medical Director of immediate jeopardy. Starting on 3/26/2025 the Director of Nursing/Designee will initiate in-service on adequate supervision to prevent a resident from leaving the facility, including policies on elopement/missing resident. In the event a resident starts exhibiting exit seeking behavior that are not controlled with the following interventions redirection, assessing for unmet needs, assessing for pain, hunger, toileting, personal care, and increase in activities, the care plan team will evaluate the need for 1:1 and or alternate placement. This will be discussed during clinical morning meeting and quarterly care plan meetings for residents who reside on the secure unit. All staff including new hires and agency will be in-serviced on this policy prior to beginning their next shift. This will be completed by 3/26/2025. On 3/26/2025 12 residents residing on the secure resident, none are actively exit seeking, they are not attempting to climb out windows or exit doors. Residents were assessed by IDT round to include Administrator, Director of Nursing, Regional Nurse Consultant and direct care staff. Residents were assessed with an elopement risk assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 3/26/2025 The policies for one on one have been created to include the following: Residents are placed on one on one there will be a third designated person assigned to the resident & not part of the usual staffing pattern. Criteria for 1:1 would be a resident exhibiting self-harm and uncontrolled behaviors posing risk to self and others. 1:1 supervision is defined as resident will be within line of sight of staff. Interventions used prior to placing a resident on 1:1 would be redirections, assessing pain, hunger, unmet need, toileting, and personal items. On 3/25/2025 the Resident #3 was discharged to a more a different facility with a more secure unit to eliminate the risk of elopement by this resident. Ad-Hoc QAPI meeting was held on 3/26/2025, with the Medical Director, NHA (Nursing Home Administrator), Regional Nurse Consultant, Director of Nursing, and Assistant Director of Nursing to review the alleged deficiency, policy and procedure, and the plan for removal of immediacy. Starting on 3/26/2025, IDT (Interdisciplinary team), including Administrator, Director of Nursing an Assistant Director of Nursing will review the head count and checks window to ensure they are secure with L bracket to prevent opening more than 6 inches in the secure unit of the facility daily Monday to Friday, and Manager on Duty Saturday and Sunday. Any negative findings will be immediately brought up to the Administrator/Designee for further action, if necessary. This will continue daily for the next 14 days. Then weekly there after. Starting 3/26/2025 RDO or designee will provide physical oversight at facility weekly x4 weeks and then monthly x 2 months. The Administrator/designee will monitor compliance by physical plant rounds Monday through Friday; Manager on Duty will monitor on weekends. Any identified concerns will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance for next 2 months. The Administrator will be responsible for ensuring this plan is completed on 3/26/2025. The RDO/Designee will provide oversight of Administrator to ensure that the items on the plan of removal are reviewed and completed. Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interviews, and record review from 03/27/2025 at 5:17 PM to 03/28/2025 at 4:45 PM as follows: During an observation on 03/25/2025 between 4:45 and 4:50 PM all window in the secure unit were observed to have L brackets placed in each window. Record review of facility's EMR assessment section residents residing on secure unit on 03/28/2025 at 08:25 AM revealed elopement assessments for 12 residents currently residing on secure unit. 11 of 12 residents identified as elopement risk. Record review of the facility provided agenda for the Ad-Hoc QAPI meeting held on 3/26/2025 revealed that the MD had attended meeting and signed the agenda. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands	125 Inspiration Blvd Eastland, TX 76448

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of electronic medical records revealed the 12 residents on the secure unit had an elopement risk assessment completed on 03/26/2025. Record review of facility provided policy revealed a policy titled One on One Resident Supervision. During an interview on 03/25/2025 at 8:40 AM the ADMN stated Resident #3 had been excepted to another facility and would be transported today to new facility. During an observation and record review on 03/25/2025 at 4:00 PM Resident #3 was not located on the secure unit. Record review revealed he had been discharged to another facility. Record review on 03/28/2025 at 09:00 AM, observed and reviewed in-services for staff located at nurses station, for One on One, Resident Rights, Staffing on Secure Unit, Elopement, and Exit seeking. Observed sign-in sheets for each in-service. Observed DON conducting an in-service with a dietary staff member. Record review of the facility provided agenda for the Ad-Hoc QAPI meeting held on 3/26/2025 revealed meeting was held and attendees had signed. Record review of facility provided documents revealed facility was performing head count and window checks daily. During an interview on 03/28/2025 at 09:10 AM, CNA A stated she was in-serviced on 03/27/2028 by DON on resident rights, secure unit staffing, one on one, exit seeking, and elopement on 03/27/2025 by DON. CNA A stated one on one was making sure resident was in line of sight and staying with them and not helping with other residents. CNA A stated the secure unit should have 2 staff on all shifts, if resident was exit seeking should try to redirect and call for help if needed. If a resident elopes, she was to try to find the resident, let the charge nurse know, do room check and head count. Residents have the right to make their own choices, refuse care, and know what medicines they are getting. During an interview on 03/28/2025 at 09:15 AM, NA G stated she was in serviced on 03/27/2025 by DON resident rights, one on one, staffing of secure unit, exit seeking and elopement on 03/27/2025 by DON. Staffing of secure unit with at least 2 staff unit each shift. NA G stated one on one meant always keeping resident in line of sight. NA G stated if residents were exit seeking to try to redirect or see if they are hungry. NA G stated residents had the right to refuse care, treated with respect, and make decisions. During an interview on 03/28/2025 at 09:20 AM, LVN H stated she was in-services on 03/27/2025 by DON on One-to One, Staffing on Secured Unit, Resident Rights, Exit Seeking, and Elopement on 03/27/2025 by DON. LVN H stated one on one meant keeping resident in line of sight and not leaving resident until another staff member can take over one on one. LVN H stated the secure unit should have been staffed with 2 staff at all times. LVNH stated if a resident was exit seeking staff should try to re-direct resident, offer food or see if the resident was in pain. LVN H stated residents had the right to refuse care, to be treated with respect and to make their own decisions. (continued on next page)

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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 - Some	During an interview on 03/28/2025 at 09:30 AM, CNA I stated the secure unit should have 2 staff at all times, one on one meant to keep the resident in line of sight and to not leave them without someone to take the staff's place. CNA I stated for elopement should let charge nurse know, check all rooms, all areas of facility to try to locate resident. CNA I stated she had in-services on 03/27/2025 by ADON before her shift. CNA stated residents had the right to refuse care, treated with respect, and make decisions. CNA I stated other in-services she had today included Exit Seeking, Resident Rights, Staff on Secure Unit, and Elopement. During an interview on 03/28/2025 at 09:45 AM, AD said she received in-services on 03/28/2025 by DON on resident rights, one on one, secure unit staffing and elopement secure unit staffing. The AD stated one on one was keeping the resident in line of sight and secure unit should have 2 staff on all shifts. The AD stated if a resident was trying to elope to try to re-direct, get other staff to help. The AD stated if resident had eloped check on other residents, try to find missing resident and report to ADM, DON and other staff. The AD stated residents had the right to make their own choices, be treated with respect and have needs taken care of. During an interview 03/28/2025 at 09:55 AM, NA F stated she had been in-serviced on 03/28/2025 by DON on one on one, resident rights, staff on secure unit, elopement and exit seeking. NA F stated one on one meant staying with resident and keeping your eyes on them. NA F stated if resident eloped need to try to find them, call DON and ADM and let other staff know someone is missing. NA F stated residents had to the right to refuse care, treated with respect, and make decisions. Transport Aide F stated the residents had the right to be treated with respect, and to make their own choices. During an interview on 03/28/2025 at 10:28 AM, CNA J stated she worked night shift and had in-services 03/27/2025 by DON on one on one, staffing of secure unit, elopement, exit seeking, and resident rights. CNA J stated she would assist on secure unit when needed and one on one meant to keep the resident in line of sight and not leave the resident. CNA J stated if a resident was exit seeking to try to re-direct them or offer them something to eat and if a resident elopes to let all staff know, try to locate resident and notify ADM and DON and make sure all other residents are accounted for. CNA J stated residents had to the right to refuse care, treated with respect, and make decisions. During an interview on 03/28/2025 at 11:05 AM, LVN K stated she had [TRUNCATED]

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44558 Based on observation, interviews, and record review, the facility failed to have sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident and determined by considering the number, acuity, and diagnoses of the facility's resident population with accordance with 1 of 13 residents (Resident #3) reviewed for sufficient staffing The facility failed to provide sufficient staffing of Secured Locked Unit for resident with known history of elopement that required 1:1 supervision on 03/24/2025. An Immediate Jeopardy (IJ) was identified on 03/21/2025. While the IJ was lowered on 03/28/2025 at 4:45 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm with a scope of pattern, due to the facility's need to evaluate the effectiveness of their corrective actions. This failure could place the residents at risk of residents' needs, safety and psychosocial well-being not being met. The findings include: Record review of Resident # 3's face sheet dated 03/24/2025 revealed a [AGE] year-old female admitted on [DATE] with a readmission on 02/19/2025 with the following diagnoses cardiac issues, seizures, and traumatic brain injury. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed: Section C - Cognitive Patterns Resident #3 had a BIMS of 14, meaning cognitively intact. Section GG Mobility Devices Resident #3 required the use of a walker. Record review of Resident #3's Care Plan updated on 03/21/2025 revealed: Problem: start date 10/09/2024 I am on the memory care unit due to exit seeking behaviors. On 3/21/25 had actual Elopement through bedroom window-High Risk 20. Goal: Resident will remain free from injury related to exit seeking/elopement attempts through next quarter. Approach: Start Date 03/21/2025 Consider Medication Review if behaviors continue or escalate; Start Date- 03/21/2025 Consider psych consult with increase in behaviors; Start Date- 03/21/2025 Ensure all basic needs are met when resident. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	becomes anxious or aggressive. Offer toileting, snack, fluids, comfort. Etc.; Start Date- 12/05/2024 Resident must be accompanied by staff while in courtyard. Start Date- 10/09/2024 Assess/ record/ report to MD risk factors for potential elopement such as: wandering, repeated requests to leave facility, attempts to leave facility. Start Date- 10/09/2024 Check doors & windows for security and for proper functioning and placement per facility protocol. Start Date-10/09/2024 Develop and activities program to divert. attention and meet needs for social, cognitive stimulation; Start Date- 10/09/2024 Discuss with resident/ family risks of elopement. and wandering; Start Date- 10/09/2024 If resident is missing from facility, follow elopement protocol, notify MD and family. immediately, and document; Start Date- 10/09/2024 Placement on secure unit for high risk for elopement; Start Date: 10/09/2024 Supervise closely and make regular compliance rounds whenever resident is in room. Record review of Resident #3's physician orders revealed Start date of 10/09/2024 Admit to facility secure unit. Record review of Resident #3's progress notes revealed: Date 03/23/2025 at 4:52 PM documented by LVN C Resident exit seeking this shift. Eloped from Memory Care unit into ALF and was exiting ALF dining room door that leads to highway. Resident stopped outside door and escorted back to Memory Care. No injuries noted, Resident denies pain. Date 03/24/2025 at 1:07 PM documented by DON Clarification to note on 06/23/25 at 1652: Spoke with on duty memory care CNA on date of entry. CNA states res approached door in memory care dining room. Resident pushed on door, causing door alarm to sound. CNA immediately recognized and responded to alarm. CNA reports res was standing outside door of memory care dining room next to building. Res immediately redirected resident back through memory care dining room door without difficulty. Staff will perform 1 on 1 resident observation at this time until further placement arrangements can be made. During an observation on 3/24/2025 at 9:55 AM Resident #3 was sitting in his room on his bed, no staff was in his room or within the proximity of his room. During an observation on 03/24/2025 between 12:35 and 12:40 PM, CNA B was sitting at the dining room table assisting a resident with eating their lunch, NA Z was assisting another resident in the resident's room. One resident was trying to open doors and another resident was scraping food from one plate to another plate (that were not theirs) and pouring food on to the floor. CNA B appeared flustered while trying to provide care for the three residents in the dining area. Resident # 3 left the dining area and went to his room. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 03/24/2025 at 3:20 PM, Resident #3 was standing in the hallway on the secure unit with his walker. Resident #3 stated he wanted to go home and that is why he ran away yesterday. Resident #3 went into his room and sat on his bed. CNA B was observed walking away from Resident #3's room, no staff were observed in room with Resident #3. During an interview on 03/24/2025 at 4:20 PM, CNA B stated she and NA Z were the staff who had been working on the secure unit that day. CNA B stated she was not aware Resident #3 was supposed to be on 1:1 supervision. CNA B stated she and NA Z were taking turns watching Resident #3. CNA B stated 1:1 supervision meant a staff constantly with a resident. CNA B stated when a resident was on 1:1 supervision staff documented on a log their observations of resident. CNA B stated she had not been notified Resident #3 was on 1:1 supervision by the nurse or the DON. CNA B stated she had not been given a log to document 1:1 supervision. CNA B stated whoever was doing the 1:1 supervision should have been writing it down. CNA B stated the DON or nurse had not told her that she needed to do one on one for Resident #3. During an interview on 03/24/2025 at 4:30 PM, NA Z stated she had not been notified that Resident #3 was on 1:1 supervision. During an interview on 03/25/2025 at 10:35 AM, the DON stated Resident #3 was placed on 1:1 supervision on 3/23/2025, after he exited the secure unit, until a new placement could be found. The DON stated her expectation was that Resident #3 be within line of sight of staff. The DON stated that if Resident #3 was in his room, he could not be seen by staff. The DON stated the aides on the secure unit were responsible to provide 1:1 supervision for Resident #3 and different staff would come and assist on the secure unit. The DON stated she was not aware there was times Resident #3 was not on 1:1 supervision. During an interview on 03/25/2025 at 11:45 PM, the ADMN stated her expectation was that Resident #3 was placed on 1:1 supervision on 3/23/2025 after he exited the building. The AMDN stated her expectation of 1:1 supervision was that Resident #3 should have been within line of site of a staff at all times. The ADMN stated NA Z, CNA B and LVN P were responsible for 1:1 supervision along with department staff throughout the day. The ADMN stated if Resident #3 was in his room there should have been a staff member within line of site. The ADMN stated she was not aware Resident # 3 had been in his room without staff. The ADMN did not have an explanation to why staff did not know about the 1:1 supervision., she stated staff should have been notified at the beginning of their shift. The ADMN stated they did not have a policy for 1:1 supervision. During an interview on 03/25/2025 at 1:15 PM, the MD stated he had provided care for Resident #3. The MD stated due to Resident #3's traumatic brain injury he was not capable of making decisions on his own and was not safe to be out of facility on his own. The MD stated the facility was on a major highway and if Resident #3 were to have gotten out of the facility, he could have had the potential of being stuck by a motor vehicle. The MD stated having only one staff on the secure unit during a shift was not sufficient staff to supervise all the resident's needs. Record review of facility policy title, Staffing, Sufficient and Competent Nursing dated August 2022, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility assessment.' This was determined to be an Immediate Jeopardy (IJ) on 03/21/2025 at 4:31 PM. The Administration was informed of the IJ. The Administrator was provided with the IJ template on 03/26/2025 at 12:30 PM. Record review of Plan of Removal accepted on 03/27/2025 at 5:17 PM reflected the following: FACILITY: [Facility Name] Facility ID Number: 110493 SURVEY TYPE: Complaint Survey SURVEY DATE: 3/26/2025 Plan for REMOVAL Plan to remove immediate jeopardy. The facility failed to provide sufficient staffing of Secured Locked Unit for resident with a known history exit seeking and elopement that required 10-15 minute safety checks and 1:1 supervision. F 725 On 3/26/2025 the Administrator notified the Medical Director of the immediate jeopardy. On 3/26/2025 None of the 12 residents residing on the secure unit are identified as inappropriate for the secure unit at this time. The 12 residents residing in the secure unit were assessed by the IDT team to include the Administrator, Director of Nurses, Regional Nurse Consultant and direct care staff for appropriate placement. An elopement risk assessment was also completed on all 12 residents on 3/26/2025. On 3/26/2025 The policies for one on one have been created to include the following: Residents are placed on one on one there will be a third designated person assigned to the resident & not part of the usual staffing pattern. Criteria for 1:1 would be a resident exhibiting self-harm and uncontrolled behaviors posing risk to self and others. Interventions used prior to placing a resident on 1:1 would be redirections, assessing pain, hunger, unmet need, toileting, and personal items. On 3/25/2025 the resident #3 was discharged to a different facility with a more secure unit to eliminate the risk of elopement by this resident. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Starting on 3/26/2025 the Director of Nursing/Designee will initiate in-service for all staff including new hires and agency prior to working next scheduled shift including weekends and nights on adequate supervision to be defined as two facility staff members at all times present on the secure unit. Staffing from other departments will be reassigned to work in the secure unit if needed for both day and night shifts. Residents change of condition are discussed with the care plan team during the morning meeting, quarterly, and as needed. The facility will access the need for additional interventions when evaluating the changes in a resident's condition. Ad-Hoc QAPI meeting was held on 3/26/2025, with the Medical Director, NHA (Nursing Home Administrator), (Regional Nurse Consultant), Director of Nursing, and Assistant Director of Nursing to review the alleged deficiency, policy and procedure, and the plan for removal of immediacy. Starting on 3/26/2025, IDT (Interdisciplinary team), including the Administrator, Director of Nursing an Assistant Director of Nursing, will review staffing schedules in the secure unit to determine two staff are always in the secured unit daily Monday to Friday, and Manager on Duty Saturday and Sunday. Any negative findings for sufficient staffing will be immediately brought up to the Administrator/Designee for further action, if necessary. Administrator/Designee will send additional staff including center leadership team, center staff and/or agency as needed to meet sufficient staffing needs. Starting 3/26/2025 RDO or designee will provide physical oversight at facility weekly x4 weeks and then monthly x 2 months. The Administrator/designee will monitor compliance by reviewing staffing schedule and assignment sheet and staff present Monday through Friday. The Weekend Manager on Duty will monitor compliance on weekends by reviewing staffing schedules and assignment sheets. Any identified concerns will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance for next 2 months. The Administrator will be responsible for ensuring this plan is completed on 3/26/2025. The RDO/Designee will provide oversight of Administrator to ensure that the items on the plan of removal are reviewed and completed. Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interviews, and record review from 03/27/2025 at 5:17 PM to 03/28/2025 at 4:45 PM as follows: Surveyors monitored the facility's Plan of Removal and confirmed it was sufficient to remove the IJ through observations, interviews, and record review from 03/27/2025 at 5:17 PM to 03/28/2025 at 4:45 PM as follows: During an observation on 03/25/2025 between 4:45 and 4:50 PM all window in the secure unit were observed to have L brackets placed in each window. Record review of facility's EMR assessment section residents residing on secure unit on 03/28/2025 at 08:25 AM revealed elopement assessments for 12 residents currently residing on secure unit. 11 of 12 residents identified as elopement risk. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility provided agenda for the Ad-Hoc QAPI meeting held on 3/26/2025 revealed that the MD had attended meeting and signed the agenda. Record review of electronic medical records revealed the 12 residents on the secure unit had an elopement risk assessment completed on 03/26/2025. Record review of facility provided policy revealed a policy titled One on One Resident Supervision. During an interview on 03/25/2025 at 8:40 AM the ADMN stated Resident #3 had been excepted to another facility and would be transported today to new facility. During an observation and record review on 03/25/2025 at 4:00 PM Resident #3 was not located on the secure unit. Record review revealed he had been discharged to another facility. Record review on 03/28/2025 at 09:00 AM, observed and reviewed in-services for staff located at nurses station, for One on One, Resident Rights, Staffing on Secure Unit, Elopement, and Exit seeking. Observed sign-in sheets for each in-service. Observed DON conducting an in-service with a dietary staff member. Record review of the facility provided agenda for the Ad-Hoc QAPI meeting held on 3/26/2025 revealed meeting was held and attendees had signed. Record review of facility provided documents revealed facility was performing head count and window checks daily. During an interview on 03/28/2025 at 09:10 AM, CNA A stated she was in-serviced on 03/27/2028 by DON on resident rights, secure unit staffing, one on one, exit seeking, and elopement on 03/27/2025 by DON. CNA A stated one on one was making sure resident was in line of sight and staying with them and not helping with other residents. CNA A stated the secure unit should have 2 staff on all shifts, if resident was exit seeking should try to redirect and call for help if needed. If a resident elopes, she was to try to find the resident, let the charge nurse know, do room check and head count. Residents have the right to make their own choices, refuse care, and know what medicines they are getting. During an interview on 03/28/2025 at 09:15 AM, NA G stated she was in serviced on 03/27/2025 by DON resident rights, one on one, staffing of secure unit, exit seeking and elopement on 03/27/2025 by DON. Staffing of secure unit with at least 2 staff unit each shift. NA G stated one on one meant always keeping resident in line of sight. NA G stated if residents were exit seeking to try to redirect or see if they are hungry. NA G stated residents had the right to refuse care, treated with respect, and make decisions. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/28/2025 at 09:20 AM, LVN H stated she was in-services on 03/27/2025 by DON on One-to One, Staffing on Secured Unit, Resident Rights, Exit Seeking, and Elopement on 03/27/2025 by DON. LVN H stated one on one meant keeping resident in line of sight and not leaving resident until another staff member can take over one on one. LVN H stated the secure unit should have been staffed with 2 staff at all times. LVNH stated if a resident was exit seeking staff should try to re-direct resident, offer food or see if the resident was in pain. LVN H stated residents had the right to refuse care, to be treated with respect and to make their own decisions. During an interview on 03/28/2025 at 09:30 AM, CNA I stated the secure unit should have 2 staff at all times, one on one meant to keep the resident in line of sight and to not leave them without someone to take the staff's place. CNA I stated for elopement should let charge nurse know, check all rooms, all areas of facility to try to locate resident. CNA I stated she had in-services on 03/27/2025 by ADON before her shift. CNA stated residents had the right to refuse care, treated with respect, and make decisions. CNA I stated other in-services she had today included Exit Seeking, Resident Rights, Staff on Secure Unit, and Elopement. During an interview on 03/28/2025 at 09:45 AM, AD said she received in-services on 03/28/2025 by DON on resident rights, one on one, secure unit staffing and elopement secure unit staffing. The AD stated one on one was keeping the resident in line of sight and secure unit should have 2 staff on all shifts. The AD stated if a resident was trying to elope to try to re-direct, get other staff to help. The AD stated if resident had eloped check on other residents, try to find missing resident and report to ADM, DON and other staff. The AD stated residents had the right to make their own choices, be treated with respect and have needs taken care of. During an interview 03/28/2025 at 09:55 AM, NA F stated she had been in-serviced on 03/28/2025 by DON on one on one, resident rights, staff on secure unit, elopement and exit seeking. NA F stated one on one meant staying with resident and keeping your eyes on them. NA F stated if resident eloped need to try to find them, call DON and ADM and let other staff know someone is missing. NA F stated residents had to the right to refuse care, treated with respect, and make decisions. Transport Aide F stated the residents had the right to be treated with respect, and to make their own choices. During an interview on 03/28/2025 at 10:28 AM, CNA J stated she worked night shift and had in-services 03/27/2025 by DON on one on one, staffing of secure unit, elopement, exit seeking, and resident rights. CNA J stated she would assist on secure unit when needed and one on one meant to keep the resident in line of sight and not leave the resident. CNA J stated if a resident was exit seeking to try to re-direct them or offer them something to eat and if a resident elopes to let all staff know, try to locate resident and notify ADM and DON and make sure all other residents are accounted for. CNA J stated residents had to the right to refuse care, treated with respect, and make decisions. During an interview on 03/28/2025 at 11:05 AM, LVN K stated she had in-service [AJB1] 03/27/2025 by ADON on resident rights, elopement, exit seeking, staffing on secure unit and one on one. LVN K stated the secure unit should have 2 staff on all shifts, one on one meant keeping resident in line of sight. LVN stated residents had the right to refuse care, to be treated with respect, and make their own decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675001	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woodlands	125 Inspiration Blvd Eastland, TX 76448

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/28/2025 at 11:17 AM, NA L stated received in-services [AJB2] on 03/27/2025 by DON on resident rights, one on one, secure unit staff, elopement and exit seeking and staffing on secure unit. NA L stated for resident's exit seeking to try to distract resident. Resident rights, the residents have the right to make their own choices, to be treated with respect and taken care of. NA L stated one on one means making sure you can see residents all the time you were with them, and the secure unit should have 2 staff on all shifts. NA L stated if a resident eloped, he would let the charge nurse know immediately and would begin looking for resident and making sure no one else is missing. During an observation on 03/28/2025 at 12:01 PM, the DON was on the secure unit performing head count of the residents and checking on the residents and the staff. During an interview on 03/28/2025 at 01:25 PM, the DON stated she prepared in-services for resident rights, one on one, Secure unit staffing, elopement and exit seeking. The DON stated she conducted in-services on 03/27/2025 with staff in-house on both shifts. DON stated all staff were provided handouts regarding information on all in-services. DON stated she was available to staff for any questions or concerns. During an interview on 03/28/2025 at 01:35 PM, ADON stated she assisted DON with preparing in-services on 03/27/2025 on resident rights, Secure unit staffing, one on one, Exit seeking, and elopement. ADON stated called staff not at facility or not able to come to facility for in-services and discussed in-service information with staff on phone. ADON stated handouts were available for all staff and would be given to staff unable to attend in person. During an observation on 03/28/2025 at 01:40 PM observed all the windows on secure unit had L brackets on the windows to prevent windows from being raised more than 6 inches. During an interview on 03/282025 at 02:10 PM, MM stated he checked windows L brackets on secure unit daily and if any not working they would be fixed immediately. MM stated he had a log sheet to document that L brackets were checked and secure. MM stated he had in services 03/27/2025 by ADON on one on one, secure unit staffing, resident rights and elopement and exit seeking. During an interview on 03/28/2025 at 02:45 PM, Housekeeper M stated she attended in-services on 03/28/2025 by DON for resident rights, one on one in secure unit. Staffing for secure unit, exit seeking and elopement. Housekeeper M stated one on one was keeping resident in line of sight and staying with the resident until someone else was available. Housekeeper M stated residents have the right to make choices and to kept clean and safe. During an attempted interview on 3/28/2025 at 3:45 PM the MD's office did not answer phone and a message was left. An Immediate Jeopardy was identified on 03/21/2025. While the Immediate Jeopardy was removed on 03/28/2025, the facility remained out of compliance at a level of no actual harm with a potential for more than minimal harm and a scope of pattern, due to the facility monitoring the effectiveness of their Plan of Removal. The ADMN, the DON, and the RRN were informed of the Immediate Jeopardy was removed on 03/28/2025 at 4:45 PM.