STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675030	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regent Care Center of Laredo	7001 McPherson Rd Laredo, TX 78041

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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	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** 46038 Based on observations, interviews, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one (Resident #1) of one residents reviewed for supervision. The facility failed to ensure Resident #1 received adequate supervision while Resident #1 was unaccounted for approximately 2 hours. On 04/21/2024, Resident #1 eloped from the facility through the employee dining area (formally assisted living dining area) door sometime after 1:00pm. The facility was notified by another local facility located approximately one block away at approximately 2:30 pm, that Resident #1 was brought into their facility after a passerby saw Resident #1 on the sidewalk by the road next to their facility. The passerby assumed Resident #1 resided at their facility since Resident #1 was located across the street. The noncompliance was identified as PNC. The PNC began on 04/21/24 and ended on 09/17/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents requiring supervision at risk for injury and accidents with potential for more than minimal harm. The findings included: Record review of Resident #1's face sheet dated 11/20/24 reflected an [AGE] year-old-female admitted to the facility on [DATE]. Diagnoses included Alzheimer's (brain disorder that destroys memory and thinking skills), Dementia (general decline in cognitive abilities that affects a person's ability to perform everyday tasks), and type two diabetes (insufficient production of insulin in the body). Record review of Resident # 1's elopement risk assessment dated [DATE]. Resident #1 was not found to be an elopement risk at that time. Record review of Resident # 1's physician order dated 03/12/24 reflected a Wanderguard. Record review of Resident #1's MDS dated [DATE] reflected a BIMS (brief mental score) of 3 (severe cognitive impairment) dated 3/13/24. Resident #1 was ambulatory and did not require the use of mobility devices. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 11/19/24 at 10:00 am the ADON stated the incident happened on a weekend and she received a call from the Administrator at that time that Resident #1 had eloped but was back in the facility. The ADON stated she came to the facility and checked on Resident #1 and there was no injuries or distress noted. The ADON stated a dietary aide heard the alarm on the door and looked outside but did not go outside to see if anyone was out there and did not notify any staff members. The ADON stated Resident #1 did not have exit seeking behaviors prior to the incident. The ADON stated Resident #1 did have a wander guard and the door alarm was working but was not equipped with a wander guard alarm on that door, just a regular alarm that goes off when pushed. The ADON stated Resident #1 was ambulatory and was able to walk without assistance. The ADON stated Resident #1 was calm but was unable to recall what had happened. The ADON stated LVN A stated he received a call from a nearby nursing facility asking if Resident #1 belonged to the facility. The ADON stated the nearby nursing facility stated a passerby saw Resident #1 on the sidewalk and drove her to the nearby nursing facility thinking the resident resided at that facility since Resident #1 was across the street. The ADON stated LVN A picked up Resident #1 at the nearby nursing facility and brought her back to the facility where the ADON conducted a head-to-toe assessment. The ADON stated there are no exit seeking residents at this time. The ADON stated Resident #1 was picked up by her family the next day and taken home. In a phone interview on 11/19/24 at 10:36 am the Dietary Aide stated he was washing dishes when he heard an alarm go off. The Dietary Aide stated he went to the employee dining room, looked out the door and the windows and did not see anyone. The Dietary Aide stated it was his mistake that he did not go outside to check if there was a person and did not notify staff. In a phone interview on 11/19/24 at 11:02 am LVN A stated the incident was a long time ago and was not sure if he could remember the details. LVN A stated he remembered receiving a call from the nearby nursing facility to let them know they had a resident at the facility they thought was their resident. LVN A stated he drove to the nearby nursing facility and brought Resident #1 back to the facility and conducted a head-to -toe assessment and there were no obvious injuries reported. LVN A stated he could not remember when the nearby nursing facility called, but stated he last saw Resident #1 around 1:00 pm in the main dining room eating and he had left to continue his rounds. LVN A stated Resident #1 did not appear to be in any distress and Resident #1 could not recall the incident but was happy to see LVN A. LVN A stated Resident #1 did not display exit seeking behaviors prior to the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 11/19/24 at 11:46 am the nearby nursing facility weekend supervisor stated the receptionist called her to the front stating a resident was found outside and was brought in by someone passing by. The nearby nursing facility weekend supervisor stated the person driving by stated they saw Resident #1 on the sidewalk by the road and brought her to their facility because it was lightly raining outside and thought it was odd she was outside and was possibly a resident at their facility. The nearby nursing facility weekend supervisor stated Resident #1 stated she was ok and that she lived down the block. The nearby nursing facility weekend supervisor stated she noticed Resident #1 had a wanderguard on her ankle and realized Resident #1 was from another facility. The nearby nursing facility weekend supervisor stated she called the facility and asked if they had a resident by the name the Resident #1 gave. The nearby nursing facility weekend supervisor stated the line got disconnected and she called the facility multiple times with no answer, so she called the local law enforcement for assistance. The nearby nursing facility weekend supervisor stated the police came to the facility and informed the other facility they needed to pick up the resident after confirming Resident #1 did reside at the facility. The nearby nursing facility weekend supervisor stated a nurse from the facility came and took the resident back to the facility Resident #1 resided in. The nearby nursing facility weekend supervisor stated that was sometime in the afternoon, approximately around 1:00 to 5:00 pm. In an interview on 11/19/24 at 4:26pm the Administrator stated all employees were re-trained on the elopement process and the new door locks/alarms when [NAME] took over on 9/17/24 as well as replaced all doors locking mechanisms and added extra security with replacing cameras and installing a two-way communicator at the nurse's station and receptionist desk. The Administrator stated he was not sure what training or interventions were done when the incident originally took place but when he came on board, he started brand new with re-educating all staff and adding the extra security to ensure it did not happen again. The Administrator stated he was not the administrator at the time of the elopement but there has not been an elopement of any resident since the incident. In an interview on 11/20/24 at 9:30am the Director of Clinical Operations stated when [NAME] took over, they immediately conducted an ADHOC (a meeting that is necessary or needed) meeting and a 4-point plan including complete door and camera assessment, ordering of equipment, resident re-assessments, and education. The Director of Clinical Operations stated the facility has continued elopement education monthly and were continuing elopement drills. Stated there has not been another elopement incident since. In an interview on 11/20/24 at 10:44am the Maintenance Director stated the back dining room exit door was no longer accessible to residents as the dining room is no longer in use. The MD stated all the exit doors have been upgraded with new locking mechanisms, a new wanderguard alarm was installed on the front door cameras have been installed/repaired, and the front door remains locked at all times and the receptionist has a fob to open it. The MD stated at the nurse's station, a monitor was installed that alerts staff when an exit door is opened and displays what exit door has been. The MD stated there was now a two-way communication speaker at the front door that connects to the nurse's station and receptionist area. The MD stated all staff were trained on the new exit doors and how they work. The MD stated he was conducting Monday through Friday exit door checks to ensure all exit doors are functioning properly. The MD stated all exit doors when opened, will alarm and the alarm will not turn on off unless a code or key is used. The MD stated the facility now uses the TELS (program used for work orders and facility maintenance needs) program for all maintenance needs so he can be aware if there are issues with a door as well as anything in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's Elopement Response and Exit Seeking Management policy dated January 2023 stated: B. Response following the location of the resident: 1. Once located and safety confirmed, conduct an assessment. 2. Place resident on enhanced monitoring, consider 1:1 for a specified time as needed to ensure the safety of resident or consider placement in secured unit for continued monitoring and safety. The IDT should review and determine the continued need for additional monitoring efforts. 3. Update the Exit Seeking-Elopement Risk Assessment as indicated. 4. Review and/or update the care plan as indicated. 5. If the community is equipped with a Wander Guard or Roam Alert System, assess the resident's need for a wander guard or roam alert monitoring device (i.e. bracelet); if needed, obtain order from physician and notify representative. 6. Notify Administrator and DON 7. Notification of Physician/N.P./P.A. 8. Notification of resident's representative 9. Notify [NAME] Support & CSO Support 10. Update the plan of care accordingly. In an interview beginning on 11/19/24 at 8:30am LVN A, CNA B, LVN C, SW, Admissions Coordinator, and Dietary Aide from various shifts were able to identify the elopement process, wandering residents, knowledge on the new door alarms/locks, what to do if the door alarm sounds, locate cause of alarm, do not reset alarm without determining who entered or exited, identify code orange as the elopement code, and the different types of abuse and neglect. Record review and verification of the corrective action implemented by the facility beginning on 04/21/24: Resident #1 was discharged from the facility on 4/22/24. oResident #1 was placed on 15-minute checks and 1:1 monitoring. Verified through record review and interview with ADON on 11/20/24. oRe-educated and in-serviced staff beginning on 04/21/24 regarding: Verified through interviews with various staff members and record review of in-services on 11/20/24. -Elopement and Wandering Residents (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-What to do when door alarm sounds, locate cause of alarm, locate person who went out or in the door. -Do not reset alarm without determining who entered or exited. oAll new admissions will have wandering assessment completed. Verified through record review on 11/20/24. oAll residents were assessed for elopement risk begnning on 4/21/24. Verified through record review and interview with ADON on 11/20/24. oDaily (Monday-Friday) exit door checks by maintenance, notify administrator immediately if any of the doors appear to malfunction. Verified through interviews with Maintenance Director and record review of maintenance log on 11/19/24. oAll residents have an updated wandering assessment. Currently no residents are an elopement risk. Verified through record review and interview with DON and Administrator on 11/20/24/ oRemoved all non-functional and abandon door locking devices beginning on 9/17/24. Verified through record review of invoices and interviews with Maintenance Director and Administrator on 11/20/24. oAll exit doors received new touch-sensor bars with delayed egress magnetic locking hardware beginning on 9/17/24. Verified through record review, observations, and interview with Maintenance Director and Administrator on 11/19/20. oAll staff were educated on operation of new door locks. Verified through staff interviews and record reviews beginning on 11/19/24. oRewired remote door locking annunciator at nurse station to provide visual indication of unlocked doors beginning on 9/17/24. Verified through observation of nurse's station and interview with Maintenance Director and DON on 11/20/24. oRepaired camera system and replaced all non-functioning interior cameras beginning on 9/17/24. Verified through interview with Maintenance Director and record review on 11/20/24. oInstalled reset only door ajar alarms on all exit doors. Installed 10yr lithium batteries to ensure continuous operation beginning on 9/17/24. Verified through interview with Maintenance Director on 11/20/24. (Maintenance Director will monitor battery for proper functioning.) oInstalled a wander management system on the front door for enhanced security beginning on 9/17/24. Verified through observation and interview with Administrator on 11/20/24. oInstalled a two-way communication device on the front door to nurse station and receptionist desk beginning on 9/17/24. Verified through observation on 11/20/24. oInstalled a set of double egress doors (with delayed egress locks) at back corridor to ensure the back wings are secure from free access by staff and residents beginning on 9/17/24. Verified through observation and interview with Maintenance Director on 11/19/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	oAdded a digital building management system for maintenance (TELS) beginning on 9/17/24. TELS is a system used in the nursing facility where maintenance work orders can be inputted by staff members. Verified through interview with Maintenance Director and Administrator on 11/20/24. oInterviews beginning on 11/19/24 at 8:30am, various staff members were able to correctly identify the elopement procedures, what to do when the door alarm goes off, and identified code pink as the code for elopement. oNo other incidents of elopement have occurred since Resident #'1's elopement incident. Verified through record review and interview with the DON and Administrator on 11/19/24.