STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675101	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakland Manor Nursing Center	1400 N Main St Giddings, TX 78942

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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** 47065 Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of four residents reviewed for elopement. The facility failed to ensure Resident #1, who was an elopement risk, was not left outside in the secure unit courtyard by himself on 08/13/24. The noncompliance was identified as PNC IJ. The IJ began on 08/13/24 and ended on 08/18/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of not receiving their medications and meals, going missing, or sustaining injuries, dehydration, or death. Findings included: Review of Resident #1's face sheet, dated 09/25/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including unspecified dementia (a group of diseases that cause a loss of cognitive functioning that interferes with daily life), anxiety disorder, and unspecified mood disorder. Review of Resident #1's admission MDS assessment, dated 08/19/24, reflected he had a BIMS of 4, which indicated he had severe cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Review of Resident #1's care plan, dated 08/16/24, reflected he had a diagnosis of dementia and resided in the secure unit due to his known history of wandering and poor safety awareness allowing freedom of mobility. Staff noted on 08/13/24, Resident #1 eloped from secure unit courtyard stating he climbed over the fence. Interventions included refer Resident #1 to behavioral facility for evaluation and treatment, initiate 1:1 monitoring until psychological services discontinues 1:1 monitoring, psychological/psychiatric services evaluation and treatment, initiated medication review with psychologist/MD/Pharmacist as needed, Resident #1 required supervision when he wanted to go outside and encourage extra hydration, encourage to attend group activities daily, have an elopement assessment done on admission, quarterly, and with significant change in condition, provide Resident #1 with activities based on his prior lifestyle/interests if Resident #1 wanders, conduct medical evaluation per MD orders, speech will evaluate and treat for cognition, staff will monitor Resident #1 and report changes in exit seeking behaviors to the ADM, DON, physician and RP, and provide comfort measures for Resident #1's basic needs when he began to wander. Review of Resident #1's elopement risk assessment, dated 08/08/24, reflected he was at risk for elopement with an intervention of being placed in the secure unit. Review of Resident #1's progress notes reflected the following: - LVN A documented on 08/12/24 at 5:48 p.m., Resident day 3/7 admission and resident alert and oriented to self with forgetfulness. Resident noted up pacing all night and as he was pacing proceeded to knock on adjacent doors and required staff redirection. Resident would apologize to staff then continued to pace up and down hall and stated he cannot sleep. Resident will continue to be monitored. - LVN B documented on 08/13/24 at 12:20 a.m., Resident day 6/7 new admit, resident very pleasant, able to make needs known, stated to the nurse he has no pain or discomfort. Nurse noted him wandering from room to room throughout the night, open other residents room doors, he was confused as to what he need and what he was looking for. Staff had to keep directing him back to his room. -LVN B documented on 08/13/24 at 5:22 a.m., Resident did not sleep throughout the night he kept coming out of his room going into other rooms. Staff had to be redirected back into his room. -LVN A documented on 08/13/24 at 6:58 p.m., This staff was alerted by CNA staff that resident was let out to courtyard. This staff walked perimeter of the fence line and alerted other staff as well as DON of missing resident. [PD] was contacted and given description of resident wearing longhorns baseball hat along with grey shirt and khaki shorts. Head count was completed by this staff of 17 accounted for with 1 resident eloping noted 18 before elopement. [PD] then called this staff and alerted resident was found and will be returned per [PD]. Resident returned with no visible sign of injury. Resident ambulated independently back to secured unit without any behaviors and was noted happy and noted with sweaty shirt. Head to toe assessment was noted with no injuries b/p taken and noted 127/68 p74 temp 98.3 spo 97% on rrom air. Resident denies pain or distress, officer stated resident stated he had to walk because his car broke down. Resident sitting in common area water offered and taken well. This staff was then told by don 1 to 1 in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-DON documented on 08/13/24 at 8:13 p.m., This nurse went to check on resident after returning to facility. Resident was noted to be happy and sitting in recliner in common area drinking water. Resident noted to have sweat on T-shirt. resident ask where he went and he stated for a long walk. Resident denied pain and had no noted visible sign of injury. I ask resident if he could he show me what he did and he said yes, physical therapist and myself walked him outside in courtyard and resident went to fence pointing up to a post and showing us that he just grabbed up and pulled over the fence. resident was easily redirected to inside the building. I ask resident if he would like more water and a snack and he stated yes. Water and pizza was provided to staff and he ate all and drank as he was eating. Resident remains happy and joking. states that he is a little tired now. -DON documented on 08/13/24 at 9:13 p.m., I went to check on resident and he was in bed at this time, I ask if he would like to shower and he declined at this time, I did a head to toe assessment and noted no bruises or scratches to body on anterior or posterior side. Left knee noted to be red in color and resident stated hit it on fence. Resident given glass of water and tolerated well. MD notified of elopement with med review done and stated no lab to be done at this time. Medical director notified as well. Resident remains one on one monitoring at this time. -DON documented on 08/13/24 at 9:31 p.m., I notified resident [family] about elopement and updated on resident overall condition. Resident [family] stated he did this at home all the time. [Family] states they went hiking all the time with me as I am a wildlife photography and he can out do me for sure. [Family] stated he is appreciative for the update and has no concerns at this time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a group interview on 09/25/24 at 10:31 a.m., the DON and the HRC stated Resident #1 was a new resident. The DON and the HRC stated Resident #1 was in the facility's secure unit courtyard and hopped over the fence. The DON and the HRC stated staff searched for Resident #1, notified the police, and found him. The DON stated her and a physical therapist took Resident #1 out to the secure unit courtyard again and Resident #1 demonstrated how he climbed over the fence. The DON and the HRC stated Resident #1 was in the secure unit courtyard getting fresh air. The DON and the HRC stated they did not know if anyone was outside in the secure unit courtyard with Resident #1. The DON stated CNA C let Resident #1 out into the secure unit courtyard, went to check on another resident, came back to secure unit courtyard, noticed Resident #1 was missing, and notified a night shift nurse. The DON stated she was in the facility when staff notified her that Resident #1 was missing. The DON stated Resident #1 told staff that he wanted to leave, when asked why he climbed over secure unit courtyard fence. The DON stated Resident #1 also told staff he climbed over the secure unit courtyard fence because his car broke down and he was trying to find a phone. The DON stated Resident #1's family told staff that Resident #1 would leave home in the past. The DON stated Resident #1 never eloped at the facility in the past and had been at the facility for one week since admission. The DON stated CNA C told her that Resident #1 did not leave the secure unit courtyard in the past, wanted to go outside, let him out, and did not think he would climb over the fence. The DON stated Resident #1 had no prior exit-seeking behaviors, but Resident #1's family told her that Resident #1 would leave the house in the past prior to his admission, which was why he was considered exit-seeking. The DON stated she believed the secure unit courtyard fence was approximately 8-10 feet and CNA C did not think Resident #1 would climb the fence and leave. The DON stated staff implemented visual observations of Resident #1 and had psychological services visit Resident #1 following the incident. The DON stated Resident #1 was no longer on 1:1 monitoring at the time of the interview because psychological services told staff that they could stop 1:1 monitoring of Resident #1. The DON stated staff documented all 1:1 monitoring performed on Resident #1. The DON stated Resident #1 had short-term memory issues. The DON stated Resident #1's family wanted to place Resident #1 in a facility because he wanted to wander out of the house and would get up and leave the house. The DON stated staff were educated on elopement and other trainings. The DON stated staff did not have orientation training specifically on the topic of elopement prior to beginning employment. The DON stated staff were in-serviced monthly and with elopement being one of the topics reviewed. The DON stated staff were taught to be out in the secure unit courtyard accompanying and supervising residents following Resident #1's incident. The DON stated before Resident #1's incident, residents could walk in the secure unit courtyard, staff could frequently check on residents and were not required to supervise residents in the area. During an interview on 09/25/24 at 10:46 a.m., the DON stated Resident #1 was sent to a behavior hospital on 08/28/24 because of his exhibited aggressive behaviors towards another resident and returned 09/13/24 because he had no behaviors in the hospital. The DON stated Resident #1 did not exhibit any aggressive or exit-seeking behaviors since returning from the hospital. An observation of the secure unit courtyard on 09/25/24 at 11:46 a.m. reflected the courtyard was empty, there were no residents in the area at the time of the observation, there was a fence that stretched the entire landscape with no openings, and approximately 10 feet tall. An observation of the door leading to the secure unit courtyard on 09/25/24 at 11:51 a.m. reflected a sign posted on the door that indicated, Do not let residents out of the facility unassisted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/25/24 at 11:56 a.m., CNA D stated she could not recall when staff posted the sign on the door leading to the secure unit courtyard, but she believed it was a month or two months ago. During an interview on 09/25/24 at 11:59 a.m., LVN E stated she was given orientation training on elopement and in-serviced by the DON 2-4 times in the last four months on the topic. LVN E stated if a resident asked to go to the secure unit courtyard, she was trained to go out to the courtyard with the resident. LVN E stated she would also bring the resident inside and not leave the resident alone in the secure unit courtyard if another resident needed her help. LVN E stated if a resident was not in the secure unit courtyard, she was trained to initiate the facility's missing resident protocol, start searching the resident, and immediately notify the DON. LVN E stated she never observed a resident climb over the secure unit courtyard fence and did not know how Resident #1 climbed over the secure unit courtyard fence. LVN E stated Resident #1 had no exit seeking behaviors since his incident. LVN E stated Resident #1 was placed on 1:1 monitoring following his incident and taken off 1:1 monitoring after psychological services verified, he was okay. LVN E stated the CNAs and supervising nursing staff initiated Resident #1's 1:1 monitoring. During an interview on 09/25/24 at 12:11 p.m., CNA D stated she was given orientation training on elopement and in-serviced by the DON two weeks ago on the topic. CNA D stated if a resident asked her to go to the secure unit courtyard, she was trained to go out to the secure unit courtyard with them. CNA D stated she would bring the resident back inside the facility and not leave the resident alone in the secure unit courtyard if another resident needed her help. CNA D stated if a resident was not in the secure unit courtyard, she was trained to notify a nurse. CNA D stated there was also a doorbell for assistance in the secure unit courtyard. CNA D stated she helped conduct 1:1 monitoring for Resident #1 every 15 minutes after his incident. CNA D stated Resident #1 had no previous or subsequent elopement incidents. CNA D stated she documented Resident #1's 1:1 monitoring on physical log sheets. CNA D stated she never had a resident climb over the secure unit courtyard fence. CNA D stated she did not know how Resident #1 climbed over the secure unit courtyard fence because Resident #1 did not have any marks, scratches, or scars. CNA D stated Resident #1 had no exit seeking behaviors since the incident. CNA D stated Resident #1 was taken off 1:1 monitoring after psychological services verified, he was okay. During an interview on 09/25/24 at 12:23 p.m., the MR stated she helped supervise residents in the secure unit. An observation of the secure unit and interview on 09/25/24 at 12:24 p.m. reflected Resident #2 wandering to the secure unit entrance doors. CNA D monitored and redirected Resident #2 away from the doors. Resident #2 stated she was doing fine, felt safe, never wanted to leave the facility, and staff checked on her. An observation of the secure unit on 09/25/24 at 12:26 p.m. reflected Resident #3 wandering to the secure unit entrance doors. LVN E monitored and redirected Resident #3 away from the doors. An attempt to interview Resident #3 was made, but he was unable to answer any questions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation and interview of Resident #1 on 09/25/24 at 12:28 p.m. reflected he had no scratches, marks, or scars. Resident #1 stated he could not remember how and why he climbed over the secure unit courtyard fence, but he believed it was determination. Resident #1 did not explain why it was determination. Resident #1 stated he also could not remember how long he was away from the facility after he climbed the secure unit courtyard fence. Resident #1 stated he never attempted to climb over the secure unit courtyard fence after his incident. Resident #1 stated he felt safe, staff checked on him often, he had no injuries from his incident, and did not want to leave the facility. An attempt to contact Resident #1's RP was made on 09/25/24 at 12:46 p.m. A voicemail and call back number was left. Resident #1's RP did not return the call prior to exit. During an interview on 09/25/24 at 12:47 p.m. the NP stated staff notified her about Resident #1's elopement episodes. The NP stated Resident #1 tried to leave when he was admitted , which was why he was assigned to reside in the secure unit, because staff had an elopement unit. The NP stated she was notified whenever Resident #1 tried to leave the facility. The NP stated Resident #1 had behavior issues. The NP stated police were called when Resident #1 somehow climbed over the secure unit courtyard fence. The NP stated staff encouraged Resident #1 to come back to the facility. The NP stated to her knowledge, Resident #1 was never out of staff's sight. The NP stated to her understanding, Resident #1 broke through the secure unit courtyard fence and did not climb over the fence. The NP stated Resident #1 was always trying to leave, but he never got that close to leaving the facility. The NP stated Resident #1 medications changed and staff had no problems since he returned from the behavior hospital. The NP stated she heard about Resident #1's incident 1-2x weeks before his transfer to a behavior hospital. The NP stated she last visited Resident #1 at the facility 3 weeks ago. The NP stated she reviewed Resident #1's new medications implemented at the behavior hospital and continued the medications after he returned from the behavior hospital because they were effective. An attempt to contact LVN A was made on 09/26/24 at 9:42 a.m. A voicemail and call back number was left. LVN A did not return the call prior to exit. An attempt to contact CNA F was made on 09/26/24 at 9:43 a.m. An attempt to leave a voicemail and call back number was made, but there was an automatic message that indicated the person the user was trying to reach was not accepting calls at the time and automatically ended the call after the message. An attempt to contact LVN G was made on 09/26/24 at 9:44 p.m. A voicemail and call back number was left. LVN G did not return the call prior to exit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/26/24 at 11:09 a.m., CNA C stated she was given orientation training on elopement and in-serviced by the DON on the topic. CNA C stated if a resident asked her to go to the secure unit courtyard, she was trained to go with the resident. CNA C stated before the training, she was trained to supervise residents within eyesight from the inside of the facility whenever a resident requested to go out into the secure unit courtyard. CNA C explained she would have another staff member monitor the resident in the secure unit courtyard if another resident asked her for help while another resident was in the secure unit courtyard. CNA C stated she was working in the secure unit when Resident #1 eloped from the facility two months ago. CNA C stated Resident #1 asked her if he could go out to the secure unit courtyard and she allowed Resident #1 to go in the secure unit courtyard. CNA C explained residents could go into the secure into courtyard and be supervised by staff within eyesight at the time of the incident. CNA C explained she went back inside the facility to help lie a resident down into bed, returned 5 minutes later, observed Resident #1 was gone from the secure unit courtyard, and immediately notified the nurse. CNA C stated there was another CNA who was supposed to work on her shift the day of the incident, but the CNA called out sick. CNA C stated the DON, LVN G, and LVN A were working at the time when she notified them that Resident #1 was missing. CNA C stated Resident #1 was placed on 1:1 monitoring after his incident. CNA C stated she participated in monitoring Resident #1 every 15 minutes and documented the monitoring she performed on physical log sheets. Review of Resident #1's elopement risk evaluation, dated 08/13/24, reflected he was at risk for elopement with additional interventions of being placed in secure unit, structural activities, and ensuring room was located close to nursing stations and away from exit doors. Review of Resident #1's orders reflected an order by the MD on 08/13/24 to place Resident #1 on one-on-one monitoring through the night and then monitor every 15 minutes for 72 hours. The order was discharged by the MD on 08/28/24 because Resident #1 was discharged to the behavior hospital on 08/28/24. Review of Resident #1's psychological evaluation note, dated 08/20/24, reflected he was seen by psychological services 1-5 times a month. Session summary indicated, Patient reported that he missed his home and family very much and reported he thought frequently about returning home. When asked, patient reported he did remember trying to make one elopement attempt reporting that he thought he would go to [NAME]. Patient was a poor historian, he initially reported he had zero family in the area and had no children. Later in the interview, he reported that he did have sons and one son was living somewhere in [NAME]. He acknowledged one escape attempt, reporting that he could vaguely remember going over the fence, but could not remember any details about additional attempts. Plan was to see patient one week to assist with identifying coping strategies to assist with reducing anxiety and improving adjustment as well as referring him for psychiatric evaluation to assist with identifying medications that might assist with reducing agitation and improving his adjustment. Review of Resident #1's psychologist progress note, dated 08/27/24, reflected Resident #1 reported that he continued to miss home, but did not think about eloping because he would have nowhere to go. Plan was to consult with Resident #1's staff regarding his psychotropic medications and supervision and the plan was to see him in two days to reevaluate his status and assist with behavior management. Review of Resident #1's 1:1 monitoring sheets, 08/23/24-08/28/24, reflected staff checked on him every 15 minutes and he had no exhibited abnormal behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's census report, dated 09/25/24, reflected he discharged on [DATE] and returned 09/13/24. Review of the facility's provider investigation report reflected Resident #1's incident happened on 08/13/24 at 7:41 p.m. in the secure unit and was reported to SA on 08/14/24 at 7:00 p.m. Resident #1 was placed on 1:1 monitoring for 3 days after the incident. There were notices placed on all doors that indicated, No resident should be outside without supervision. Staff were educated on abuse and neglect, wandering, and elopement. Staff also conducted elopement practice drills on 08/13/24. CNA C was interviewed and stated on 08/13/24, she let Resident #1 into the secure unit courtyard at 6:45 p.m. because he asked, she went to change another resident's brief, came back around 7:00 p.m., noticed Resident #1 was not in visible site, and notified the charge nurse on duty. Resident #1 was interviewed and stated he grabbed a bar and climbed over the fence when staff asked him how he got out of the secure unit courtyard. Staff reviewed the facility's missing resident and elopement and wandering policies on 08/13/24. Staff accounted for all residents during their head count except Resident #1 at the time of his incident. Staff also checked all maintenance records on for all doors and gates and ensured they were operable, locked, and secured from 08/12/24 through 08/22/24. Gates and doors passed inspection during the previously mentioned timeframe. All residents were reevaluated for elopement risk observation and had care plans reviewed and revised with new interventions implemented. Staff also verified that all residents' electronic health records included photos of the residents. Staff also updated residents' elopement risk records. Staff were educated on behavior and communication on 08/22/24. Resident #1's progress notes and care plan were updated. Staff were also educated on aggressive behavior on 08/14/24, off-duty call in on 08/13/24, missing resident on 08/13/24, wandering elopement and running away on 08/14/24, abuse and neglect on 08/13/24, and secure unit gates at unknown date. Staff initiated 1:1 monitoring on Resident #1 every 15 minutes from 08/13/24 through 08/18/24. There were no subsequent incidents of elopement. Staff initiated 15 resident safety surveys on 08/14/24, which found residents reported never been harmed by any staff or other residents, never witnessed any form of mistreatment by any staff or other residents, felt safe at facility, staff treated them with respect, and knew who to report mistreatment to. Review of the facility's incident and accident reports reflected Resident #1's elopement incident was documented on 08/13/24 at 8:06 p.m. in which he was placed on 1:1 monitoring every 15 minutes for 72 hours and had a medical work up completed. Review of the facility's admission/discharge report reflected Resident #1 was discharged to a behavior hospital on 08/28/24. Review of the facility's wandering, elopement, and running away policy, undated, reflected the following: Wandering: Random or repetitive locomotion that may be foal directed, non-goal directed, or aimless. Elopement: Occurs when a resident leaves the premises or safe area unplanned. Running Away: Occurs when a resident is in distress about admission to a facility. Review of the facility's emergency policy and procedure for missing resident, revised December 2021, reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy statement: Resident elopement resulting in a missing resident is considered a center emergency. Policy Interpretation and Implementation: 1. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety. 2. Staff will implement the protocol for missing resident immediately upon discovering that a resident cannot be located. Review of the facility's wandering and elopements policy and procedure, undated, reflected the following: Policy Statement: The facility will ensure that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Definitions: 'Wandering' is random or repetitive locomotion that may be goal-directed (e.g., the per on appears to be searching for something such as an exit or person), non-goal directed, or aimless. 'Elopement' occurs when a resident leaves the premises or safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The noncompliance was identified as PNC IJ. The IJ began on 08/13/24 and ended on 08/18/24. The facility had corrected the noncompliance before the survey began.