STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 of 7 residents (Resident #1) reviewed for neglect. Resident #1 was identified as confused and a wanderer and had increased confusion but was not monitored more closely. The facility did not report to HHSC when Resident #1 was discovered in traffic on a busy street on 7/27/24. This failure placed the resident at risk for harm. Findings included: Record review of Resident #1's face sheet dated 7/30/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were cognitive communication deficit, muscle weakness, unsteadiness on feet, lack of coordination, and stroke. Record review of Resident #1's quarterly MDS dated [DATE] indicated a BIMS score of 3 (severely cognitively impaired.) The MDS did not indicate any memory problems, mood issues or behavioral symptoms. The resident required partial to moderate assist with the helper doing less than half the effort for transfers and sit to stand. (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: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 2/28/24 and last revised on 5/28/24 indicated a Focus area of impaired cognitive function or impaired thought process related to a stroke. He wandered into other resident rooms and used the bathroom. He urinated on his jacket and would not allow it to be cleaned. One of the interventions was to redirect the resident when he wandered into other rooms. A Focused area dated 7/27/24 and last revised 7/30/24 indicated Resident #1 was at risk for elopement related to Elopement Risk sore. He had a wander guard in place. Some of the interventions were engage the resident in activities of his choice. Report to MD factors for potential elopement such as wandering, repeated request to leave the facility, and attempts to leave. Ensure the wander guard was in place. Record review of Resident #1's Elopement Risk Evaluation dated 5/19/24 indicated a score of 1 with no risk of elopement. The form indicated if there was a yes to question 1 or 2 then the form was complete. Question one indicated the resident was able to make decisions regarding task of daily living and decisions were consistent and reasonable. The question was answered yes. However, additional information indicated the resident was at risk for elopement related to Elopement Evaluation risk score, the goals were he would remain safe within the facility unless accompanied by staff or authorized persons. The intervention was to engage the resident in actives of his choice. Record review of Resident #1's Elopement Risk Evaluation dated 7/27/24 indicated a score of 15 (imminent Risk for elopement.) The form indicated Resident #1 was unable to make decisions regarding task of daily living, and he was unable to ambulate. The patient was cognitively impaired and had a history of leaving the community without informing staff. Additional information the resident is an elopement risk related to Elopement Evaluation risk score. Record review of Resident #1's nursing note dated 7/27/24 at 12:37 a.m. indicated the resident continued day 10 of 10 of an antibiotic for UTI. He was pleasantly confused and was out of bed and self-propelling using his lower extremities about the facility. He had his clothes piled up in his wheelchair and was sitting on them as if they were a cushion. It was difficult to re-direct the resident, and he did not know what time it was. He was also redirected due to the fact that he would stand and attempt to walk and it looked like he was having balance issues. He was frequently reminded to sit in his wheelchair. Will continue to monitor. Record review of Resident #1's History for Police Event (#242090341) indicated on 7/27/24 at 4:18 p.m. they received a call a resident had rolled away from the nursing home. At 4:19 p.m. the caller said the resident is in the middle of the street and they are trying to get him out of the roadway. They have blocked traffic to get him moved. At 4:31 the patent was rolled back to the location by staff who did not know he had even left. At 4:33 p.m. Resident #1 said he was out to see a friend at the apartments next door. He was advised that it was dangerous out on the roadway with vehicles. He was assisted back to facility. The resident said he would never do that again and that it was scary. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an incident report dated 7/27/24 at 4:28 p.m. indicated Resident #1 was reported by and off duty staff member to be outside in the area adjacent to the facility in his wheelchair rolling himself with his feet. The resident was returned to the facility by law enforcement and wheeled to his room. The resident was asked how he was able to leave the facility and he stated he just went out the door himself. When the resident was asked how he opened the door he said you do not need a code to open the door from the inside. When the resident was asked what door, he went out. He said he went out the front door. When the resident was asked how he got down the stairs he said he did not go down any starts he was on the ground floor, the resident was confused and not aware of the current situation. The form indicated the resident was oriented to person, impulsive with a lack of safety awareness. Predisposing environmental factors were recent illness, confusion, and impaired memory. Predisposing situational factors where the resident was a wanderer. Record review of statements dated 7/27/24 from CNA I and CNA L that placed the resident in and around the 200 hall about 4:15 p.m. The facility provided a timeline for their investigation 8/1/24 at 12:30 p.m. with no date. The typed form indicated on 7/27/24 at 4:15 CNA I noted Resident #1 self-propelling self in wheelchair in hallway. At 4:18 p.m. CNA L noted Resident #1 sitting at the dining room table. Between 4:10 p.m. and 4:20 p.m. the family of another resident was noted in and out of the 300-hall door moving a resident belongings. At 4:26 p.m. Resident #1 was brought back to the facility by the police. With no signature. Record review of TULIP (HHSC system for reporting abuse) indicated no facility report was located for 7/27/24 for Resident #1. During an interview on 7/30/24 at 9:28 a.m. the ADON P said Resident #1 was the resident that the police bought back on 7/27/24 and he was just on the side of the building. She said to the best of what they could figure out there was a family in the building picking up a resident's belonging, she said they felt like Resident #1 had gone out the door by kitchen/ nurses' station with those family members on 300 hall. She said Resident #1 was not considered at risk for wandering until 7/27/24. She said Resident #1 was confused at times but had never tried to leave. She said the nurse on duty LVN A said the police brought the resident back and only waved at her. The nurse said the floor tech brought Resident #1 back into to the facility. During an interview on 7/30/24 at 9:45 a.m. Resident #1 said he did not remember leaving the facility on 7/27/24. He could not say where he lived now or where he used to live. He only said, I live here. He did say he used to go fishing every day and told fish stories. He was confused. During an interview on 7/30/24 at 9:55 a.m. LVN B said Resident #1 was confused. She said she had never heard him say he was going to leave. She said a while back he thought his family was coming to take him home. He would pack his clothes and say he was waiting on his family to come and get him. She said he would place his clothes in the chair behind him. However recently he had not said anything about leaving. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER: Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/30/24 at 10:47 a.m. LVN A said on 7/27/24 around 4:00 p.m. LVN A said she was doing last med pass. She saw Resident # 1, he had been up and down the hallway all day, and she kept an eye on him due to his increased confusion. LVN A said Resident #1 had a UTI and had just finished antibiotics. She said he was wandering up and down the halls more than usual. LVN A said a group of family came to get another resident's belonging. She said Resident #1 had gone to the common area and the several members of a family walked in from the 300 hall. The LVN said she did not hear any alarms going off. She said the family members had been in and out of the facility multiple times. She said the doors were all locked and it was not easy to get out of the facility. She said another nurse called and said Resident #1 was outside about 4:28 p.m. She said she left by the side door of the 200-hall floor. LVN A said when she saw Resident #1 he was between the building parking lot and the apartment building across the street. She said when she saw him he was being wheeled up the ramp by Floor Tech C. LVN A said the Police had him and the floor tech went and got him. She said the police did not ask her name or speak to her, they only waved and left. She said she had tried to complete a skin assessment on Resident #1 but as soon as she removed one piece of clothing, he was putting another piece of clothes on. She said Resident #1 did not complain of any pain to her. She said Resident #1 told her he went out the ground floor. However, he could not because there were steps down to the ground level on the first floor. She said he exit to parking lot on the 300-hall looked like it is at the ground level. She said the family removed a lot of stuff, gave two big boxes and a couple of trash bags, and their hands were full. LVN A said they may not have seen the resident exit the facility with them. She said that was the way the staff pieced together Resident #1's possible exit. LVN A said she had texted ADON P to let her know the family had come to get the resident things at 4:17 right before the family left. She said she received a call on 7/27/24 at 4:28 p.m. and was notified Resident #1 was missing and outside with the police. She said that either way he went out the door would have been downhill. She said she had never seen him stand or walk. During an interview on 7/30/24 at 12:25 p.m. the Administrator said he knew Resident #1 had left the faciity on [DATE]. He said they had come to the conclusion he was not trying to elope. He said no staff he interviewed had seen him exit the building, but they felt he had got caught up in the traffic of the family leaving the facility. The Administrator said they did not think Resident #1 was trying to elope, and he was found by the apartments across the street. He said the staff did not know he was gone. He said he was not aware of the police saying anything about where he was found but they believed from what the nurse said he was just across the street and not on the main street in front of the facility. The Administrator said he was the abuse coordinator. He said they deliberated calling Resident #1's elopement, but Resident #1 did not have an intent to leave and he was only gone a short time. He said Resident #1 was only gone about 10 minutes as best they could determine with staff interviews. So he had not reported the incident to the State agency. He said he had not talked to Floor Tech C. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 7/30/24 at 12:35 p.m. Floor Tech C said he was upstairs on the second floor on 7/27/24. He said he was not sure of the time, but he was looking out the patio doors and he saw several police cars. He said a female officer was approaching the front door and he went down to answer the door. He said there were 3 police cars and one emergency vehicle parked by the corner of the facility. He said the officer wanted to know if Resident #1 was their resident. He said they wanted someone to escort Resident #1 back in the building. He said when he saw Resident #1, he was on the major street by the facility. Floor Tech C said Resident #1 said he hurt his hand because he could not stop his wheelchair from going down the hill so fast. He said the resident had passed the facility, crossed the street on the same side of the street, and had rolled down to almost the next street. He said he had turned around somehow but he was in the street because there was no sidewalk. Floor Tech C said Resident #1 said he was glad he did not get by car. He said Resident #1 said he was glad they had come to get him because he was scared a car was going to hit him. The Floor Tech said Resident # 1 was trying to figure out why so many police were there. He said he had wheeled Resident #1 back into the facility from the wheelchair access on the side of the building. He said no one had asked him where the resident was located when he got him from the police. During an interview on 7/31/24 at 10:58 a.m. the Administrator said he had done an investigation regarding Resident # 1 leaving the facility. He said that he had interviewed staff on duty, and they were very direct on the time that they had last seen the resident. He said he did not interview the Floor Tech C, no one had told him was really involved with the incident. He was told a Floor Tech brought Resident # 1 back into the facility. He said CNA I said that she had last seen the resident between 4:10 p.m. and 4:15 p.m. He said LVN A said that she had gotten a call at 4:28 saying that the police had the resident outside. The Administrator said he said that he had not attempted to contact the family because they had just lost a relative. He said that he felt that Resident #1 had got caught up in the door when the family was leaving. He said the family should not have had a code and he does not know who let them in and who let them out or who let the resident out of the facility. During an interview on 7/31/24 at 11:20 a.m. the DON said Resident #1 was more confused since he had a UTI. During an interview on 8/1/24 at 12:30 p.m. the Administrator he had not called the incident in regarding Resident #1, but he realized it should have been called into the state. He said he realized also that he did not take all the steps to complete a thorough investigation. He said from his initial reports it appeared the resident only made it across the street to the apartments and did not get to the stop sign on the main street. Record review of the facility Abuse Prevention and Prohibition Program policy last revised 8/2020 indicated Physical Neglect was inadequate provision of care, leaving someone unattended who needed supervision. An investigation consisted of the facility promptly and thoroughly investigating reports of resident neglect. The facility would interview any witnesses. Reportable events that did not result in serious bodily injury the Administrator would make a telephone report in 24 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 19401

Based on observations, interviews, and record review the facility failed to ensure a resident received adequate supervision to prevent accidents for 1 of 7 residents reviewed for accidents (Resident #1).

The facility failed to ensure Resident #1 who was identified as confused and a wanderer and had increased confusion was monitored more closely.

Resident#1 was found on a high traffic street in a wheelchair in the street, with no sidewalk and a few inches for a holder on 7/27/24.

The facility staff did not know the resident had eloped, or exactly how he left the facility.

An Immediate Jeopardy (IJ) was identified on 07/31/24. While the IJ was removed on 08/01/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

This failure could result in serious harm and possible death of a resident.

Findings included:

Record review of Resident #1's face sheet dated 7/30/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE]. Some of his diagnoses were cognitive communication deficit, muscle weakness, unsteadiness on feet, lack of coordination, and stroke.

Record review of Resident #1's quarterly MDS dated [DATE] indicated a BIMS score of 3 (severely cognitively impaired.) The MDS did not indicate any memory problems, mood issues or behavioral symptoms. The resident required partial to moderate assist with the helper doing less than half the effort for transfers and sit to stand.

Record review of Resident #1's care plan dated 2/28/24 and last revised on 5/28/24 indicated a Focus area of impaired cognitive function or impaired thought process related to a stroke. He wandered into other resident rooms and used the bathroom. He urinated on his jacket and would not allow it to be cleaned. One of the interventions was to redirect the resident when he wandered into other rooms. A Focused area dated 7/27/24 and last revised 7/30/24 indicated Resident #1 was at risk for elopement related to Elopement Risk sore. He had a wander guard in place. Some of the interventions were engage the resident in activities of his choice. Report to MD factors for potential elopement such as wandering, repeated request to leave the facility, and attempts to leave. Ensure the wander guard was in place.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Elopement Risk Evaluation dated 5/19/24 indicated a score of 1 with no risk of elopement. The form indicated if there was a yes to question 1 or 2 then the form was complete. Question one indicated the resident was able to make decisions regarding task of daily living and decisions were consistent and reasonable. The question was answered yes. However, additional information indicated the resident was at risk for elopement related to Elopement Evaluation risk score, the goals were he would remain safe within the facility unless accompanied by staff or authorized persons. The intervention was to engage the resident in actives of his choice. Record review of Resident #1's Elopement Risk Evaluation dated 7/27/24 indicated a score of 15 (imminent Risk for elopement.) The form indicated Resident #1 was unable to make decisions regarding task of daily living, and he was unable to ambulate. The patient was cognitively impaired and had a history of leaving the community without informing staff. Additional information the resident is an elopement risk related to Elopement Evaluation risk score. Record review of Resident #1's nursing note dated 7/27/24 at 12:37 a.m. indicated the resident continued day 10 of 10 of an antibiotic for UTI. He was pleasantly confused and was out of bed and self-propelling using his lower extremities about the facility. He had his clothes piled up in his wheelchair and was sitting on them as if they were a cushion. It was difficult to re-direct the resident, and he did not know what time it was. He was also redirected due to the fact that he would stand and attempt to walk, and it looked like he was having balance issues. He was frequently reminded to sit in his wheelchair. Will continue to monitor. Record review of Resident #1's History for Police Event (#242090341) indicated on 7/27/24 at 4:18 p.m. they received a call a resident had rolled away from the nursing home. At 4:19 p.m. the caller said the resident is in the middle of the street and they are trying to get him out of the roadway. They have blocked traffic to get him moved. At 4:31 the patent was rolled back to the location by staff who did not know he had even left. At 4:33 p.m. Resident #1 said he was out to see a friend at the apartments next door. He was advised that it was dangerous out on the roadway with vehicles. He was assisted back to facility. The resident said he would never do that again and that it was scary. Record review of an incident report dated 7/27/24 at 4:28 p.m. indicated Resident #1 was reported by and off duty staff member to be outside in the area adjacent to the facility in his wheelchair rolling himself with his feet. The resident was returned to the facility by law enforcement and wheeled to his room. The resident was asked how he was able to leave the facility and he stated he just went out the door himself. When the resident was asked how he opened the door he said you do not need a code to open the door from the inside. When the resident was asked what door, he went out. He said he went out the front door. When the resident was asked how he got down the stairs he said he did not go down any starts he was on the ground floor, the resident was confused and not aware of the current situation. The form indicated the resident was oriented to person, impulsive with a lack of safety awareness. Predisposing environmental factors were recent illness, confusion, and impaired memory. Predisposing situational factors where the resident was a wanderer. Record review of a one-to-one activity dated 7/27/24 at 4:30p.m. indicated Resident #1 was paced on one-to-one observation for 24 hours after eloping. Record review of a nursing note dated 7/27/24 at 5:00 p.m. indicated Resident #1 had a skin assessment completed upon return to the facility, there was no bruising, no abrasions noted, and no signs and symptoms of injury or trauma. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's computerized physician orders dated 7/27/24 indicated, may have wander guard due to potential elopement. Record review of a nursing note dated 7/27/24 at 10:50 p.m. indicated the resident was sitting on the side of the bed pleasantly confused. He was one on one active with wander guard to the right ankle in place. There had been no attempts to elope at that time. Record review of Resident #1's nursing note indicated it was created on 7/30/24 at 10:09 a.m. the effective date was 7/27/24 at 6:00 p.m. The note indicated at approximately 4:10 p.m. to 4:15 p.m. the resident was observed by CNA wheeling himself down the hall passed the nurses station toward the common area of the 200 hall. At approximately 4:30 p.m. he was returned to the facility and assessed. The patient remained in the building with no further incidents. Signed by LVN A. Record review of statements dated 7/27/24 from CNA I and CNA L that placed the resident in and around the 200 hall about 4:15 p.m. The facility provided a timeline for their investigation 8/1/24 at 12:30 p.m. with no date. The typed form indicated on 7/27/24 at 4:15 CNA I noted Resident #1 self-propelling self in wheelchair in hallway. At 4:18 p.m. CNA L noted Resident #1 sitting at the dining room table. Between 4:10 p.m. and 4:20 p.m. the family of another resident was noted in and out of the 300-hall door moving a resident belonging. At 4:26 p.m. Resident #1 was brought back to the facility by the police. With no signature. During an interview on 7/30/24 at 9:28 a.m. the ADON P said Resident #1 was the resident that the police bought back on 7/27/24 and he was just on the side of the building. She said to the best of what they could figure out there was a family in the building picking up a resident's belonging, she said they felt like Resident #1 had gone out the door by kitchen/ nurses' station with those family members on 300 hall. She said Resident #1 was not considered at risk for wandering until 7/27/24. She said Resident #1 was confused at times but had never tried to leave. She said the nurse on duty LVN A said the police brought the resident back and only waved at her. The nurse said the floor tech brought Resident #1 back into to the facility. During an interview on 7/30/24 at 9:45 a.m. Resident #1 said he did not remember leaving the facility on 7/27/24. He could not say where he lived now or where he used to live. He only said, I live here. He did say he used to go fishing every day and told fish stories. He was confused. During an interview on 7/30/24 at 9:55 a.m. LVN B said Resident #1 was confused. She said she had never heard him say he was going to leave. She said a while back he thought his family was coming to take him home. He would pack his clothes and say he was waiting on his family to come and get him. She said he would place his clothes in the chair behind him. However recently he had not said anything about leaving. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 7/30/24 at 10:47 a.m. LVN A said on 7/27/24 around 4:00 p.m. LVN A said she was doing last med pass. She saw Resident # 1, he had been up and down the hallway all day, and she kept an eye on him due to his increased confusion. LVN A said Resident #1 had a UTI and had just finished antibiotics. She said he was wandering up and down the halls more than usual. LVN A said a group of family came to get another resident's belonging. She said Resident #1 had gone to the common area and the several members of a family walked in from the 300-hall. The LVN said she did not hear any alarms going off. She said the family members had been in and out of the facility multiple times. She said the doors were all locked and it was not easy to get out of the facility. She said another nurse called and said Resident #1 was outside about 4:28 p.m. She said she left by the side door of the 200-hall floor. LVN A said when she saw Resident #1, he was between the building parking lot and the apartment building across the street. She said when she saw him, he was being wheeled up the ramp by Floor Tech C. LVN A said the Police had him and the floor tech went and got him. She said the police did not ask her name or speak to her, they only waved and left. She said she had tried to complete a skin assessment on Resident #1 but as soon as she removed one piece of clothing, he was putting another piece of clothes on. She said Resident #1 did not complain of any pain to her. She said Resident #1 told her he went out the ground floor. However, he could not because there were steps down to the ground level on the first floor. She said he exit to parking lot on the 300-hall looked like it is at the ground level. She said the family removed a lot of stuff, gave two big boxes and a couple of trash bags, and their hands were full. LVN A said they may not have seen the resident exit the facility with them. She said that was the way the staff pieced together Resident #1's possible exit. LVN A said she had texted ADON P to let her know the family had come to get the resident things at 4:17 right before the family left. She said she received a call on 7/27/24 at 4:28 p.m. and was notified Resident #1 was missing and outside with the police. She said that either way he went out the door would have been downhill. She said she had never seen him stand or walk. During an interview on 7/30/24 at 12:25 p.m. the Administrator said he knew Resident #1 had left the faciity on [DATE]. He said they had come to the conclusion he was not trying to elope. He said no staff he interviewed had seen him exit the building, but they felt he had got caught up in the traffic of the family leaving the facility. The Administrator said they did not think Resident #1 was trying to elope, and he was found by the apartments across the street. He said the staff did not know he was gone. He said he was not aware of the police saying anything about where he was found but they believed from what the nurse said he was just across the street and not on the main street in front of the facility. The Administrator said he was the abuse coordinator. He said they deliberated calling Resident #1's elopement, but Resident #1 did not have an intent to leave and he was only gone a short time. He said Resident #1 was only gone about 10 minutes as best they could determine with staff interviews. So he had not reported the incident to the State agency. He said he had not talked to Floor Tech C. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 7/30/24 at 12:35 p.m. Floor Tech C said he was upstairs on the second floor on 7/27/24. He said he was not sure of the time, but he was looking out the patio doors and he saw several police cars. He said a female officer was approaching the front door and he went down to answer the door. He said there were 3 police cars and one emergency vehicle parked by the corner of the facility. He said the officer wanted to know if Resident #1 was their resident. He said they wanted someone to escort Resident #1 back in the building. He said when he saw Resident #1, he was on the major street by the facility. Floor Tech C said Resident #1 said he hurt his hand because he could not stop his wheelchair from going down the hill so fast. He said the resident had passed the facility, crossed the street on the same side of the street, and had rolled down to almost the next street. He said he had turned around somehow but he was in the street because there was no sidewalk. Floor Tech C said Resident #1 said he was glad he did not get by car. He said Resident #1 said he was glad they had come to get him because he was scared a car was going to hit him. The Floor Tech said Resident # 1 was trying to figure out why so many police were there. He said he had wheeled Resident #1 back into the facility from the wheelchair access on the side of the building. He said no one had asked him where the resident was located when he got him from the police. During an interview on 7/31/24 at 10:58 a.m. the Administrator said he had done an investigation regarding Resident # 1 leaving the facility. He said that he had interviewed staff on duty, and they were very direct on the time that they had last seen the resident. He said he did not interview the Floor Tech C, no one had told him was really involved with the incident. He was told a Floor Tech brought Resident # 1 back into the facility. He said CNA I said that she had last seen the resident between 4:10 p.m. and 4:15 p.m. He said LVN A said that she had gotten a call at 4:28 saying that the police had the resident outside. The Administrator said he said that he had not attempted to contact the family because they had just lost a relative. He said that he felt that Resident #1 had got caught up in the door when the family was leaving. He said the family should not have had a code and he does not know who let them in and who let them out or who let the resident out of the facility. During a telephone interview on 7/27/24 at 12:50 p.m. the family member of another resident said they were at the facility on 7/27/24 to pick up their family members belongings. The family member said they did not see a resident go out of the facility with them. She said they did not have a code for the doors, she said a facility staff had to let them in and out of the facility. She said Resident #1 was on the highway when they were leaving the facility. She said when they saw him his wheelchair appeared to be stuck in a rut. She said he could not move, and a family member had called the police. The family member said Resident #1 was down the street with no sidewalk. The family member said when they asked him where he was going, he said he just left and did not want to get hit by a car because they were driving by fast. The family member said about 3 officers and EMS showed up. The family member said Resident #1 told one of the officers watch his leg because he had fallen. During an interview on 7/31/24 at 11:20 a.m. the DON said Resident #1 was more confused since he had a UTI. During an interview on 8/1/24 at 12:30 p.m. the Administrator he had not called the incident in regarding Resident #1, but he realized it should have been called into the state. He said he realized also that he did not take all the steps to complete a thorough investigation. He said from his initial reports it appeared the resident only made it across the street to the apartments and did not get to the stop sign on the main street. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/31/24 at 9:20 a.m. LVN F said she worked at the facility 5 years. She said the door by the nurse's station on the 300 hall was always locked. She said she had never given out the code to any family members. The LVN F said she had worked on 7/27/24 on the 300 hall. She did not see anyone coming or going. She said around 4:00 p.m. to 4:30 p.m. she was down the hall passing medications. She said on 7/27/24 they had two nurses and three aides. She said she did not see a family come in, she did not let them in, and she did not see them leave. She said she did not hear any alarms. When the door is opened it will alarm. She said she did not see any residents exiting the door either. During an observation and interview on 07/31/24 at 9:30 a.m., the Maintenance Supervisor showed the exits on the first floor required walking down stairs or exit into a courtyard. The exits on the second floor required walking downstairs or using the elevator to get downstairs to the first floor. The exit in the dining room that went to the smoke break area opened into a courtyard that was gated. Observation of the 300 hall showed all three exit doors had coded locks on the doors. The door to the parking lot right beside the nurse's station was the most used according to the Maintenance supervisor. He said the door to the west end of the hall was used mostly by laundry because that was where it exited to. The door to the East end of the hall was used mostly by maintenance. The door by the 3d floor nursing station was used by families and staff to enter and exit and that door required a code. The outside of the facility revealed the facility sat at the corner of an intersection. The facility sat on a hill so the driveway to get to the street and the sidewalk on the side of the facility were both downhill. The side of the facility faced a busy street with 3 lanes of traffic and a speed limit of 40 miles an hour. The facility was between two hospitals, it has a highway to the south and the cities loop to the north. The street was crowed with physician offices and business. The front of the facility faced a side street and across that street were some apartments. The front of those apartments also faced the street with the high-volume traffic and there was no sidewalk in front of the apartments and only a 21-inch shoulder. The Maintenance Supervisor said most wheelchairs were 22 inches wide. The side of the facility with the busy street had a sidewalk that measured 4 feet 10 inches at the widest and 3 feet 11 inches where an electric pole took up part of the sidewalk. At the end of the sidewalk, it measured 4 feet 1 inch. The drop off from the sidewalk to the street was 11 inches at the steepest point and 5 inches at the shortest point. If the resident had rolled down hill, he would have had to come off the sidewalk and cross the two-lane residential street. Once he crossed that street there was no more sidewalk. According to interview and a picture taken by a passerby, Resident #1 had rolled his 22-inch wheelchair down a 21-inch shoulder about 125 yards (same size block as the facility- about the length of a football field) and turned around somehow and was headed back toward the facility. During an interview on 7/31/24 at 9:50 a.m. CNA H said that Resident #1 was not on any kind of monitoring prior to 7/27/24 She said that he would get his clothes and sit on them. She said he would go another residence rooms and sometimes. CNA H said Resident #1 would say that he was going to leave on occasion. She said he was confused and would call her his granddaughter. During an interview on 7/31/24 at 10:05 a.m. LVN E said she had worked at the facility on 7/27/24. She said she knew about 4:00 p.m. she started medication pass. She said at that time the family was at the facility to get the belongings of a resident. She said she saw Resident #1 in the sitting area talking to another resident and it was not 15 minutes later that they got the notification he was outside. She said that the family was there, and they were going in and out gathering a resident's things and Resident #1 may have gone out with them. LVN E said Resident #1 had just stopped taking antibiotics for UTI. She said he had intermittent confusion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/31/24 at 10:58 a.m. the Administrator said he had done an investigation regarding Resident # 1 leaving the facility. He said that he had interviewed staff on duty, and they were very direct on the time that they had last seen the resident. He said he did not interview Floor Tech C, no one had told him that he was really involved with the incident. He was told a Floor Tech brought Resident # 1 back into the facility. He said CNA I said that she had last seen the resident between 4:10 p.m. and 4:15 p.m. He said LVN A said that she had gotten a call at 4:28 saying that the police had the resident outside. The Administrator said that he had not attempted to contact the family because they had just lost a relative. He said that he felt that Resident #1 had got caught up in the door when the family was leaving. He said the family should not have had a code and he does not know who let them in and who let them out or who let the resident out of the facility. During an interview on 7/31/24 at 11:20 the DON said she thought the family that was moving a former residents' things had the code to the door because the family would come up to the facility at all hours of the night. She said she was not certain, but she also did not know how Resident #1 got out of the facility. The DON said Resident #1 was more confused since he had a UTI. During an interview on 7/31/24 at 12:55 p.m. LVN E on the 200 hall said the Elopement Book at the nurses station on 2nd floor did not have Resident #1's information but it would only take her a few minutes to put it in the book. On 7/31/24 at 3:50 p.m. the DON said Resident #1's Elopement assessment dated [DATE] was incomplete and inaccurate. She said the former interim DON had not filled the form out incorrectly. She said the form should be filled out according to the actions of the resident actively trying to exit the facility. The DON said the form should not be filled out because the resident wandered through out the facility. She said Resident #1 had a history of wandering into other residents rooms but not exit seeking behaviors. During an interview on 8/1/24 at 1:50 p.m. LVN R said she worked on 7/27/24 and was down the hall passing medications around 4:00 p.m. She said she did not see Resident #1. She did not let anyone in or out and she did not hear the door beeping. During an interview on 8/1/24 at 2:02 p.m. CNA S said she worked on 7/27/24 and did not see a family coming in and out. She did not see Resident# 1 and she did not let anyone in or out. During an interview on 8/1/24 at 2:28 p.m. CNA L said she worked on 7/27/24. She saw Resident #1 sitting at the table in the dining room between the 200 hall and 300 hall around 4:15 p.m. She said she knew it was about that time because she had come back off her break. She said she had gone to laundry on 300 hall and had to put the code in the door to exit and enter the door. She said when she came back through Resident #1 was just sitting there. She said he was sitting on some clothes and maybe a blanket. The Family of another resident had come in to get some things and it was 4 or 5 family members. She said she saw LVN A standing down the 200 hall around that time. She said she did not know how Resident #1 got out. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/1/24 at 2:43 p.m. CNA I said she worked on 7/27/24 and saw Resident #1 around 4:15 p.m. by the nurse's station on the 200 hall. She said Resident #1 said earlier in the day he was going to get his kids some school clothes. She said he was confused but he appeared to be okay. She said Resident #1 had confused some visitors with his grandchildren. She said when they brought him back from being outside Resident #1 said he left to go to the hospital. She said Resident #1 said he had burned his hands trying to stop the wheelchair from going downhill to fast, but she did not see anything. Record Review of the facility's Wandering and Elopement policy last revised 8/2020 Indicated the facility would identify residents at risk for elopement and minimize any possible injury because of elopement the procedure was licensed nurses would assess residents upon admission, readmission and quarterly and upon identification of a significant change in condition to determine their risk of wandering/elopement. Residents with a history of wander or who the IDT have assessed to be at risk for wandering or elopement would have a photograph maintained in their medical record and the Elopement /Wandering Risk binder. The Administrator and DON were notified on 07/31/24 at 4:20 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on 07/31/24 at 4:20 p.m. and a Plan of Removal was requested. The facility's Plan of Removal was accepted on 08/01/24 at 10:23 a.m. and included: [F689- Supervision to Prevent Accidents 1. The facility failed to put interventions in place to prevent Resident #1, who was confused from eloping. 2. The facility failed to follow their elopement policy 3. The facility failed to determine how Resident #1 eloped Identify residents who could be affected All residents have the potential to be affected. Identify responsible staff/ what immediate action taken 1. Resident #1 elopement assessment and care plan was audited on 7/31/24. 2. Initiated staff interviews and established a timeline of the sequence of events. 3. The DON and Administrator received a 1:1 re-education by the Regional Nurse Consultant on the facility policy and procedure on supervision of a cognitively impaired resident assessed to be at risk for elopement on 7/31/24. 4. Audit Elopement assessments on all residents currently in the facility completed on 07.31.2024. (continued on next page)

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Elopement assessments have been reviewed and or revised and deemed appropriate by the IDT on 7/31/24. 6. All residents triggering at risk for elopement were added to the elopement Book that is kept at each nurse's station. The elopement Book includes the resident's picture and face sheet completed on 7/31/24 7. Staff received re-education by the DON on the facility policy and procedure when resident exhibits exit seeking behavior on 7/31/24. 8. Staff received re-education by the DON on the facility policy and procedure in the event of a missing/wandering resident on 7/31/24. 9. Licensed Nurse and CNAs will complete an exit seeking behavior resident questionnaire starting on 7/31/24 and must complete prior to returning to work. If CNA observes resident exhibiting exit seeking behaviors, CNA will report to charge nurse. 10. The maintenance director has assessed all Exit doors in the facility to ensure that each are operating as manufacture recommendation. 11. Facility IDT has audited all key padded doors, changed codes, and areas of egress to ensure latching and lock functions are operable as designed on 7/31/24 12. Elopement assessments have been reviewed and or revised and deemed appropriate by the IDT. 13. Cameras were installed on the 300 hall exits on 7/31/24 14. A sign was placed at all exit doors reminding visitors to use the main entrance, ensure the doors are closed securely behind them. A sign was placed at all exit doors reminding visitors to use the main entrance, and ensure the doors are closed securely behind them. Staff educated not to give code out to any visitors and redirect family to use main entrance only. Charge nurses to remind families and visitors not allow residents to exit the facility with them and to notify staff if a resident is trying to leave? In-Service conducted In-service was conducted by Director of Nursing 7/31/24. The in-service is on Resident Supervision. The details of the in-service include: ? Walking Rounds ? Visualizing each resident during rounds ? Rounding every 2 hours ? Exit seeking behavior notification to DON and/or Administrator. ? 24hrs report sign off by outgoing nurse and incoming nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675133	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Highland Pines Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 N 4th St Longview, TX 75601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	? Immediately search the facility, rooms, common areas, perimeter of the building. ? Elopement binders ? Educate weekend supervisor on admission completion and necessary care planning. ? Proper completion of elopement assessments for charge nurses and ADON The in-service was attended by licensed caregivers which include Registered Nurse, Licensed Practical Nurse, Certified Nursing Assistants, Qualified medication tech, Housekeepers, Maintenance, Kitchen Staff. Staff members who are unavailable for training on this date, they will not be allowed to return to work until training is complete. This in-service was initiated on 7/31/24 and completed on 8/1/24. Implementation of Changes The changes were started by the Director of Nursing. The changes were implemented effective on 7/31/24 and will be ongoing until all staff are re-educated. The Director of Nursing will ensure competency through verbalization of understanding by staff and completion of returned questionnaire. Monitoring The Administrator/Director of Nursing/Assistant Director of Nursing will be responsible for monitoring the implementation and effectiveness of in-service on 7/31/24. ? The Administrator/Director of Nursing/Designee will monitor/review each shift change report for signature validation daily x4 weeks, then weekly x2 weeks, then monthly and report any adverse finding during QAPI ? Director of Nursing/Designee will conduct a daily audit of Elopement assessment x4 weeks, then weekly x 2 weeks, then monthly and report any adverse findings during QAPI ? Residents will be monitored by staff every shift for any exit seeking behaviors. Any changes will be reported to the Administrator Director of Nursing/Designee immediately for appropriate action. ? DON/Designee new admissions audit within 24hrs for admission for completion and necessary care plan. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 7/31/24 and conducted an Ad HOC QAPI regarding Resident #1. The Medical Director was notified about the immediate Jeopardy on 7/31/24, the Plan of removal was reviewed and accepted by the Medical Director. Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal on 7/31/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Who is responsible for implementation of process? The Director of Nursing will be responsible for implementation of New Process. The New Process/ system was started on 7/31/24.] Record review of in-service training report dated 7/31/24 indicated the subject was Supervision of Cognitively Impaired Residents (Wandering /Elopement) by the RNC. Attendees were the Administrator and the DON. They were in serviced on the elopement policy and Elopement assessments. Record review of in services dated 7/31/24 indicated the facility staff were educated on Elopement prevention and procedures to include, walking [NAME] [TRUNCATED]