STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Nursing and Rehabilitation Center of Alice	606 Coyote Tr Alice, TX 78332

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** 50039 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 4 residents reviewed for supervision. The facility failed to ensure Resident #1 received adequate supervision while Resident #1 was unaccounted for approximately 29 minutes from 4:46 PM to 5:15 PM on 08/17/24 before a 3rd party notified CNA A that Resident #1 was in her wheelchair outside the facility. The noncompliance was identified as PNC. The PNC began on 08/17/24 and ended on 09/04/24. 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 revealed a [AGE] year-old female with an original admitted [DATE] and a current admitted [DATE]. Pertinent diagnoses included Vascular Dementia with Psychotic Disturbance, muscle wasting and atrophy, and abnormalities of gait and mobility. Record review of Resident #1's Quarterly MDS assessment section C, cognitive patterns, dated 11/27/24 revealed a BIMS score of 3 (severe impairment). Record review of Resident #1's care plan revealed the problem [Resident #1] is an elopement risk/wanderer behavior of exit seeking, wandering, and agitation. 8/17/24 [Resident #1] had an actual elopement episode. Initiated on 10/21/24. Interventions listed for this problem included: -Distract resident from wandering by offering pleasant diversion, structured activities, food, conversation, television, book. Resident prefers: to have a doll that she was given and she likes to carry it with her. Initiated on 08/17/24 and revised on 08/18/24. -[Resident #1] was admitted to the secured unit. Initiated on 08/17/24 and revised on 08/22/24. (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	-Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Initiated on 12/1/22 and revised on 08/17/24. -Non-pharmacological interventions: Redirection, Offer fluids and snacks, Attend activities of choice. Initiated on 08/18/24. -Wandering evaluation tool completed. Initiated on 08/18/24 and revised on 08/22/24. Record review revealed Resident #1's elopement risk assessment dated [DATE] indicated she was not a wandering risk. Further record review revealed Resident #1's elopement risk assessment dated [DATE] indicated she was a wandering risk. Record review of the provider investigation report dated 08/20/24 revealed the following narrative: On August 17th, 2024, at approximately 5:15pm [CNA A] was notified by a visitor sitting in the front lobby that there was someone at the front door. She opened the door and was told by 3 visitors that there was someone outside who needed help. [CNA A] noticed it was [Resident #1] and immediately went outside to assist the resident. The resident was noted to be at the front of the North end of the building sitting in her wheelchair. [CNA A] immediately called [RN B] to go out to assist the resident. Resident was found to be in no distress and denied any complaints. Resident was not noted to have any s/s of dehydration. Head to toe assessment conducted with no new injuries present. Range of motion within normal limits. Resident unable to explain how she exited the building. Record review of wunderground.com revealed the temperature in [NAME], Texas on 08/07/24 from 4:51 PM to 5:51 PM to be between 94 degrees and 92 degress fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON at 1:01 PM on 12/31/24, the DON stated Resident #1 moved from the locked unit to the C hall on 03/22/24. The DON stated they performed a wandering assessment on all residents every 3 months. The DON stated at the time of the elopement, Resident #1 was not considered an elopement risk. The DON stated Resident #1 would wander the halls, and at times, wander into another resident's room looking for her room. The DON stated they never came to a definitive conclusion as to which exit Resident #1 used to leave the facility. The DON stated Resident #1 was able to propel herself while she was in her wheelchair. The DON stated Resident #1 was found at the corner of the sidewalk and grass on the side of the building in her wheelchair. The DON stated Resident #1's wheelchair was stuck in the grass at the time she was found. The DON stated CNA C noticed the side exit door's alarm was possibly malfunctioning earlier in the day but did not report it to anyone. The DON stated CNA C was suspended immediately after the incident. The DON stated RN B and LVN D performed the assessment on Resident #1 once she was back in the facility and found no signs or symptoms of distress. The DON stated after the incident, Resident #1 was put back in the locked unit before the end of the day. The DON stated if anyone suspected a resident had eloped, they would call a code grey. The DON stated the first person to respond to the alarm would go outside and check the immediate vicinity. The DON stated other nurses and aides would begin a headcount on their respective halls. The DON stated elopement drills were done quarterly before the incident, but since then they have done them monthly. The DON stated they had an elopement binder at the nurse's station containing all of the residents that had been identified as a wandering risk. The DON stated residents were not allowed to go outside the main exit without supervision because the nearby street was very busy. The DON stated they added new alarms known as screamers to the side exits to help prevent another elopement in the future. The DON stated if the resident had not gotten stuck in the grass when she eloped she may have inadvertently rolled into the nearby busy street. During an observation at 1:30 PM on 12/30/24, this state surveyor saw a binder located at the nurse's station with names and pictures of other residents in the facility identified as a wandering risk. During an observation at 1:35 PM on 12/30/24, this state surveyor paced out the distance from the exits to where Resident #1 was found outside the facility. Resident #1 was approximately 180 feet from the front door, 45 feet from the side exit, and 60 feet from a busy street. During an observation at 1:40 PM on 12/30/24, this state surveyor opened the side exit door that CNA C noted had a deficient alarm on the day of the elopement. After opening and closing the door, the screamer alarm went off for approximately 20 seconds and then shut off. The keypad did not have a red light on. The alarm tied to the keypad never sounded during the test. Several nurses and aides responded to the alarm immediately, and a head count was observed to begin on the other side of the facility by another state surveyor. In an interview with the RCNS at 1:40 PM on 12/31/24, the RCNS stated there was an elopement binder at each nursing station and at the front desk. The RCNS stated the elopement binder contained a color photo and information regarding the residents identified as wandering risks. The RCNS stated the SW was responsible for keeping the elopement binders updated. The RCNS stated they perform wandering evaluations on all residents quarterly. The RCNS stated in August the alarm had a malfunction. RCNS stated CNA C saw the door did not have a red light but did not test the alarm. The RCNS stated CNA C should have immediately informed a manager about the door malfunction. The RCNS stated if the door alarm was not working then residents could exit the facility without the knowledge of any employees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA A at 3:03 PM on 12/31/24, CNA A stated she was working from 6:00 AM to 6:00 PM on the day of the elopement. CNA A stated the incident occurred around the start of dinner. CNA A stated when she let some visitors inside through the front entrance, one of them told her there was somebody in the corner outside. CNA A stated she went outside immediately and recognized the resident as Resident #1. CNA A stated she called RN B to help her get Resident #1 back in the facility. CNA A stated Resident #1's wheelchair was stuck in the grass. CNA A stated she brought Resident #1 back inside the building with the help of RN B. CNA A stated if Resident #1 had not gotten stuck in the grass she may have rolled through the parking lot and into the street. In an interview with the MS at 9:57 AM on 01/02/25, the MS stated he had worked at the facility for approximately two years. The MS stated since the elopement they have added new alarms to each of the side exit doors. The MS stated before the elopement staff were using the side doors as an exit. The MS stated there were two side exit doors in the facility. The MS stated he and the DON had told staff repeatedly to not use the side doors as exits, and to only exit through the main front entrance. The MS stated inputting the code in the keypad disengaged the alarm for 15 seconds before it automatically reengaged. The MS stated a red light on the keypad meant the alarm was engaged. The MS stated the new alarms added to the doors could not be turned on and off via the keypad. The MS stated there was a code that would disengage the alarm indefinitely until someone input the code back into the keypad. The MS stated the code that indefinitely disengaged the alarm was removed from the system. The MS stated the alarm connected to the keypad would disengage at seemingly random times. The MS stated it would disengage itself less than one time per month. The MS stated when the alarm disengaged itself, he would have to input the code to reengage it. The MS stated employees in the past have informed him when they noticed an alarm was disengaged, and that they needed him to renengage it. The MS stated the alarms have periodically disengaged themselves since he has worked at the facility. The MS stated if a resident eloped from the facility without anybody knowing they could fall or hurt themselves and no one would be able to help. The MS stated he checked the door locks twice per day. The MS stated since the elopement they had performed one elopement drill per shift monthly. In an interview with the EC at 12:45 PM on 01/02/25, the EC stated he worked for a local electronics company. The EC stated their company came out quarterly to the facility to inspect the fire alarms, sprinklers, and the kitchen hood. The EC stated the keypad and the handy box for the doors were mismatched. The EC stated the handy box was slightly too small for the keypad. The EC stated the wires had to bend to fit the mismatched parts. The EC stated bending the wires could cause them to break or not have a good connection. The EC stated he was going to fix the keypad alarms later that day. In an interview with RN B at 1:55 PM on 01/02/25, RN B stated on the day of the elopement, CNA A called her to a resident that was outside and needed help. RN B stated she last saw Resident #1 inside the facility at 4:46 PM sitting at the front nurse's station. RN B stated she told the charge nurse to notify the family, doctor, and the DON. RN B stated they called the family to get consent to move her into the locked unit, and then moved her into it. RN B stated Resident #1 had no complaints during her assessment. RN B stated Resident #1 had no changes to her skin, no redness, and no pain. RN B stated Resident #1 had no signs or symptoms of distress. RN B stated she never heard an alarm from any of the doors. RN B stated Resident #1 may have fallen out of her chair or rolled into the parking lot during her elopement from the facility and no one would have been aware. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA C at 1:02 PM on 01/02/25, CNA C stated she was working a 6:00 AM to 6:00 PM shift on the day of the elopement. CNA C stated she saw the alarm was disengaged at around 10:00 AM to 10:30 AM. CNA C stated she was walking by with a breakfast cart when she saw the red button off. CNA C stated she went to the door to latch it and it gave a little click, but the alarm did not reengage. CNA C stated she looked for the manager on duty but got distracted by a call light. CNA C stated she got busy after that and never told her manager the alarm was disengaged. CNA C stated there were in-services and drills after the incident covering elopement procedures. CNA C stated Resident #1 could have fallen out of her chair and hurt herself outside the building and no one would have known about it to help her. An interview was attempted with Resident #1 at 1:31 PM on 01/02/25, but Resident #1 was not interviewable. During an observation at 3:07 PM on 01/02/25, this state surveyor observed the red light on one of the side exit doors. This state surveyor opened the side exit door and then closed it. The screamer alarm sounded for approximately 20 seconds. After that alarm ended, the alarm connected to the keypad continued to ring. The keypad connected alarm continued to ring until the MS entered the code into the keypad to stop it. Several staff were seen approaching the door to investigate the alarm for a possible elopement. Record review of the facility policy titled Elopements and Wandering Residents implemented on 11/21/22 revealed the following: 1. The facility may be equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. d. Adequate supervision will be provided to help prevent accidents and elopements. In interviews beginning at 1:00 PM on 12/31/25 with both day and night shift staff, CNA A, RN B, CNA C, LVN D, AA E, PT F, RN G, LVN H, the DON, the SW, the MS, and the AD 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 grey 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 08/17/24: Resident #1 was moved to the locked unit in the facility on 08/17/24 verified through record review and interview with the DON. Re-educated and in-serviced staff beginning on 08/17/24 verified through interviews with various staff members and record review of in-services on 01/02/25. - Abuse and Neglect - Wandering/exit seeking, interventions for exit seekers (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Do not give out code to non-employees - If anyone notices any doors not functioning properly immediately report - Staff to be mindful, alert, and aware of surrounding residents in the area when entering, exiting or opening doors - If you see any non employee entering the code to door report immediately - Do not use any side doors as exits, do not use override code. All new admissions have had wandering assessment completed. Verified through record review on 12/31/24. All residents were assessed for elopement risk beginning on 8/17/24. Verified through record review and interview with DON on 01/02/25. Daily (Monday-Friday) exit door checks by maintenance, notify administrator immediately if any of the doors appear to malfunction. Verified through interviews with MS and record review of maintenance log on 01/02/25. Side exit doors received new screamer alarm systems beginning on 09/04/24. Verified through record review, observations, and interview with MS 01/02/25. All staff were educated on operation of new door alarms. Verified through staff interviews (as mentioned above) and record reviews beginning on 12/31/24. Fixed keypad alarm system to not disengage at random times on 01/02/25. Verified through observation of alarm and interview with MS 01/02/25. No other incidents of elopement have occurred since Resident #'1's elopement incident on 08/17/24. Verified through record review and interview with the DON on 12/31/24. The noncompliance was identified as PNC. The PNC began on 08/17/24 and ended on 09/04/24. The facility had corrected the noncompliance before the investigation began.