STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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** 50760 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and supervision: The facility failed to supervise Resident #1 who eloped from the facility on 12/5/2024. An Immediate Jeopardy (IJ) was identified as past non-compliance on 03/05/25. The non-compliance began on 12/05/24 and ended on 12/06/24. The facility had corrected the non-compliance before the investigation began on 03/04/25. This deficient practice could place at-risk for elopement residents at-risk of harm, serious injury, or death. The findings included: Record review of Resident #1's admission record, dated 11/05/24, reflected a [AGE] year-old resident with an admitted [DATE], and diagnoses which included Alzheimer's disease, delusions, major depressive disorder with psychotic features, and encephalopathy (a disturbance of brain function which can cause confusion and memory loss). Resident #1's Quarterly MDS assessment dated [DATE] reflected a BIMS of 00 indicating severe cognitive impairment and had exhibited behaviors of wandering. Record review of Resident #1's Wandering Evaluation, dated 11/06/24, reflected him to be independent with ambulation, with a history of wandering. Record review of Resident #1's Comprehensive Person-Centered Care Plan, dated 11/06/24, reflected resident is elopement risk/wanderer. Interventions: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. 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. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. (continued on next page)

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	Record review on 3/5/25 at 8:31 AM of the Facility Provider Investigation Report, dated 12/6/24, reflected that on 12/5/24 around 6:15 AM, Resident #1 walked to a drycleaner approximately a 5-minute walk from the facility where he was found by the dietary manager. In an interview with CNA A on 3/4/25 at 6:50 PM, CNA A stated on the night of the elopement on 12/5/24, the alarm sounded at approximately 3:30 or 4:00 AM. CNA A stated she performed a head count of the residents, and all residents were present, including Resident #1. In an interview with LVN A on 3/4/25 at 7:45 PM, LVN A stated the alarm sounded around 5:00 AM to 5:15 AM. LVN A stated she looked out the window of the door to the courtyard, and it was misty outside. LVN A stated they did a head count and discovered Resident #1 was missing. LVN A stated she went back to the window of the courtyard door and saw a chair by the fence. LVN A stated the gazebo had a sofa and two chairs and one of the chairs was by the fence. LVN A stated Resident #1 could ambulate and was fit, and assumed he climbed over the fence. LVN A stated she thought Resident #1 had basic safety awareness, but with the fog and low light and his cognitive deficits, noting it was still dark outside when he left, Resident #1 could have injured himself climbing over the fence and walking through the field to get to where he was found. In an interview with the Dietary Manager on 3/5/25 at 11:19 AM, the dietary manager stated he found Resident #1 at a drycleaner across from the facility around 6:15 AM during his search for the resident which began shortly after he arrived for his shift at the facility around 5:30 AM. Resident #1 was fully dressed and had a blanket and had a bag of his belongings. The dietary manager stated that the temperature at the time was cool, not cold, and Resident #1 appeared to be in no distress, although Resident #1 did become agitated and verbally and physically aggressive when he thought the dietary manager was going to take him back to the facility. During an interview with the Acting Administrator on 3/5/25 at 3:56 PM, the Acting Administrator stated they found Resident #1 a more appropriate place that would accept him for admission. The Acting Administrator stated they did abuse, neglect and exploitation training, elopement training, elopement drills, and education on resident exit-seeking behaviors. The Acting Administrator stated there have been no elopements since Resident #1 eloped, and that he had never attempted to exit the facility before the incident. During an interview with LVN A on 3/4/25 at 7:45 PM, LVN A stated Resident #1 was discharged to the Hospital on 12/5/24 in order to find more appropriate placement. During an interview with CNA B on 3/5/25 at 12:06 PM, CNA B stated she was called in to work to provide one on one with Resident #1 until he was discharged . Record review of the Facility Provider Investigation Report on 3/5/25 at 8:31 AM revealed the medical director and responsible party were notified of the elopement on 12/5/24. The report further revealed 83 of 83 staff were in-serviced on the elopement policy and protocol from 12/5/24 to 12/6/24 and confirmed by the Administrator on 12/6/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff from the day and night shifts were interviewed regarding the incident including 2 CNAs (A and C) and 1 LVN from the night shift (LVN A), 2 CNAs (B and D) and 2 LVNs (B and C) and from the day shift, 1 Dietary Manager, 1 Maintenance Director, 1 facility receptionist, and 1 laundry aide on the day shift. The staff were able to confirm they had received the in-service training. The staff were able to verbalize what to do in the event of an elopement, who to notify, recognizing exit seeking behaviors, and the purpose of the elopement protocol. The Acting Administrator was notified on 3/6/25 at 4:18 p.m., that a past non-compliance IJ situation had been identified due to the above failure. It was determined the failure placed Resident #1 in an IJ situation on 12/5/24. The facility implemented the following interventions: In an interview with the Maintenance Director on 3/4/25 at 4:27 PM, the director stated he tested each door and alarm in the facility after the elopement on 12/5/24. On conclusion of the interview, an observation of the doors and alarms was made with the Maintenance Director. All doors and alarms were working properly during the tour and the courtyard was observed to have a couch only with no chairs. In an interview with LVN A on 3/4/25 at 7:45 PM, LVN A stated an elopement protocol binder was created and stored at the nurse's station along with descriptive information for each resident and was observed by the state surveyors during the interview. In an interview with the receptionist on 03/05/2025 at 2:50 PM, the receptionist stated there was a binder at the front desk indicating which residents can go outside the facility and was observed by the state surveyor during the interview. In an interview with the Maintenance Director on 3/4/25 at 4:27 PM, the maintenance director stated facility alarms and doors were tested on [DATE] after the elopement. Upon completion of the interview, an observation of the doors and alarms was made with the maintenance director. All doors and alarms were observed to be functioning properly. All chairs in the courtyard were observed to have been removed. During interviews on 3/4/25 from 6:50 PM to 7:45 PM two staff members, (CNA A and LVN A) stated they had received the facility in-service on elopement conducted from 12/5/24 to 12/6/24 which included information on elopement protocol, awareness of the elopement binder, and monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility. During interviews on 3/5/25 from 9:57 AM to 2:50 PM 3 CNAs (B, C, D), 2 LVNs (B, C), the Dietary Manager, 1 laundry aide and the facility receptionist stated they had received the facility in-service on elopement conducted from 12/5/24 to 12/6/24 which included information on elopement protocol, awareness of the elopement binder, and monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled, Elopements and Wandering Residents, dated 11/21/22, revealed the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents. An Immediate Jeopardy (IJ) was identified as past non-compliance on 03/05/25. The non-compliance began on 12/05/24 and ended on 12/06/24. The facility had corrected the non-compliance before the investigation began on 03/04/25.

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33866 Based on interviews and record reviews the facility failed to provide routine and emergency drugs and biologicals to residents for 1 of 6 residents (Resident #2) reviewed for pharmacy services. The facility failed to administer Resident #2's dementia medication, Memantine 10mg twice daily (a cognitive enhancer also known as Namenda) as prescribed, as the medication was never added to her MAR until the day she was discharged . As a result of this failure, Resident #2 missed all doses of her Memantine 10mg twice daily for 47 days between 07/12/2024 through 08/27/2024. This failure could place residents at risk of not achieving the therapeutic effects intended by the physician. Findings included: Record review of Resident #2's Face Sheet dated 04/04/2025 revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included: Metabolic Encephalopathy (condition where brain function is impaired due to underlying metabolic disturbance) and Alzheimer's Disease (also known as senile dementia, a progressive disease that destroys memory and other mental functions). Record review of Resident #2's Discharge Transfer Report revealed she was discharged from the facility on 08/27/2024. Record review of resident #2's Admission MDS, dated [DATE], revealed a BIMS score of 3 indicating severe cognitive impairment. Record review of Resident #2's care plan initiated 07/10/2024, revealed she had a focus area for impaired cognitive function/dementia or impaired thought processes, with interventions which included Administer medications as ordered. Record Review of Resident #2's Physician Progress note dated 07/12/2024 revealed under Section Assessment & Plan. Alzheimer's dementia - chronic illness with progression-continue memantine; and under Medication List: Memantine 10mg twice daily. Record review Resident #2's Order Summary as of 08/31/2024 revealed an order for Namenda Oral Tablet 10 mg (Memantine HCL) Give 1 tablet by mouth two times a day related to ALZHEIMER'S DISEASE, UNSPECIFIED (G30.9) with order and start date of 08/27/2024. Record review of Resident's #2's MARs from July 2024 through August 2024, revealed Memantine 10 mg twice daily was not listed on her MAR until 08/27/2024 effective 1700, the day she was discharged and was added after she was already gone from the facility, reflecting she did not receive her Memantine the entire time she was at the facility. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with a family member on 03/04/2025 at 12:25 p.m. the family member stated that when she was reviewing Resident #2's discharge medications with the discharge Nurse on 08/27/2024, she realized that Resident #2's dementia medication (Namenda) was not on the discharge medication list. When she asked about it, she discovered that the Namenda had never been started, even though it had been listed on the discharge medication list from the hospital when she was first admitted to the facility, and her physician had told them the medication would be continued at the facility. The family member stated that the discharge Nurse checked the admission note from the physician and told her that Resident #2's Namenda should have been continued while at the facility. The Nurse added the Namenda to Resident #2's medication list that day, as she was being discharged . The family member stated she visited Resident #2 frequently while she was at the facility and had noted that Resident #2 seemed to have worsening confusion. She had been receiving reports from the Nursing staff that Resident #2 was getting up at night and was out of it and she felt that some of that increased confusion may have been because Resident #2 did not receive her Namenda while at the facility. During an interview with the ADON on 03/06/2025 at 1:08 p.m., the ADON reviewed the Physician Progress Note dated 07/12/2024 and the July and August 2024 MAR's for Resident #2, and confirmed that the Nurse Practioner did order that the Memantine be continued for Resident #2. She stated it should have been added to her MAR at that time, but was not added until 08/27/2024, the day of her discharge. The ADON stated she did not know why the Memantine was not added to Resident #2's MAR, and believes it was just missed. The ADON stated that not receiving her Memantine could result in Resident #2 having worsening dementia. Interview with the Interim DON on 03/07/2025 at 2:10 p.m. revealed she has only been at the facility for about one week, but upon review of the Physician Progress Note dated 07/12/2024, and the July and August 2024 MAR's, confirmed that Resident #2 should have continued to receive her Memantine after she was admitted to the facility in July2024. She stated that not receiving medication as ordered could result in worsening of the resident's dementia. Record review of the facility policy titled Medication Reconciliation dated 4/10/2023 revealed This facility reconciles medication frequently throughout a resident's stay to ensure that the resident ifs free of any significant medication errors, and the facility's medication error rate is less than 5 percent. Further review revealed Medication Reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians and pharmacy staff. Under section titled Pre-Admission Processes: a. Obtain current medication list from referral source (hospital, home health, hospice or primary care provider); and under section titled Admission Processes: Compare orders to hospital records, etc. Obtain clarification orders as needed. Transcribe orders in accordance with procedures for admission orders.