

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/07/2025
NAME OF PROVIDER OR SUPPLIER  Parkview Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1501 S Main St Lockhart, TX 78644	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317</b></p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility after a visitor utilized the exit code then held the door open for the resident to walk out on 04/18/25 around 9:52 PM. The temperature outside was a high of 91 degrees and a low of 68. The resident was found over three hours later. She was taken to the hospital for evaluation after 1:30 AM.</p> <p>The noncompliance was identified as PNC. The IJ began on 04/18/24 and ended on 04/21/24. The facility had corrected the noncompliance before the survey began.</p> <p>This deficient practice placed residents at risk for elopements resulting in falls, injuries, dehydration, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, printed 05/07/25, reflected a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included cerebral infarction due to occlusion or stenosis of small artery (stroke), hypertension (high blood pressure), aphasia following unspecified cerebrovascular disease (difficulty speaking), expressive language disorder (difficulty speaking), and difficulty in walking.</p> <p>Review of Resident #1's admission MDS assessment, dated 04/19/25, Section C (Cognitive Patterns) reflected a BIMS assessment was not completed, nor did staff assess her short-term memory. Section GG (Functional Abilities) reflected she was independent with ADLs including transfers and walking 150 feet.</p> <p>Review of Resident #1's admission assessment and baseline care plan, initiated 04/11/25, reflected the resident was not an elopement risk but was at risk for falls.</p> <p>Review of Resident #1's Elopement Risk Assessment, dated 04/11/25, reflected a 1 which indicated no risk for elopement.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's psychosocial assessment completed 04/15/25, reflected resident was not very verbal at this time and did not answer many of the questions.</p> <p>Review of Resident #1's progress note, dated 04/19/25 at 2:15 AM, documented by the DON, reflected the following:</p> <p>During a routine round by floor nurse, a resident was reported missing from their room. All staff on duty conducted a thorough search of the entire building but were unable to locate the resident. The DON and Administrator were then called to the building to review the footage and discovered that the resident had been let out of the front door by a family member of another resident. The resident has a local address and several local family friends as emergency contacts. The Administrator contacted the resident's (family member), who resides out of state, to inform her of our findings. The (family member) stated that the resident had informed her that she was visiting a family friend in town.</p> <p>Multiple attempts were made to contact the family friend at their local physical address and via cellular phone. The (city) Police Department was notified for assistance. The DON, Dietary Manager, Administrator, and the (city) Police Department searched various areas, including the facility and the resident's housing address. The resident was located a block away from her home.</p> <p>Due to the resident's disease process, she is occasionally unable to verbally express her needs but can respond to yes or no questions and is aware of her surroundings. The resident was adamant about returning to her home rather than the facility. Once the resident was in the presence of her front door, the DON and Dietary Manager assessed her for any injuries or complications. The resident reported experiencing shortness of breath and consented to allow EMS to conduct a further evaluation. The (city) Police Department requested backup from EMS, and the resident was transported to a hospital for medical attention .</p> <p>Review of Resident #1' progress noted, dated 04/19/25 at 11:39 AM, documented by the DON, reflected the following: During a routine round, a resident was reported missing from their room around 2115. Floor nurse reports that she last time she saw her resting in bed with eyes open around 2015, All staff on duty conducted a thorough search of the entire building but were unable to locate the resident. Around 2251 The DON and Administrator were notified and arrived to building shortly after. They were able to review the camera footage and discovered that the resident had been let out of the front door by a family member of another resident around 2153. Family was notified by the Administrator. Report from floor nurse (name), LVN F. [sic]</p> <p>Review of the facility's investigation reflected the as followed: During routine rounds staff noticed the resident was missing. Staff initiated a search and verified all other residents were accounted for. When staff were unable to locate the resident, facility management were notified at 12:30 AM. Management went to the facility and assisted in the search. The administrator viewed the surveillance video and saw a visitor use a code to open the door, hold the door, and the resident walked out of the building. Family was notified and provided phone numbers and local addresses. The MD was notified. The local police were notified and assisted in the search. The codes to the doors were changed. Staff were interviewed. Staff were in-serviced on elopement, assessing risk of elopement, and codes for the exit alarms.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An observation on 05/07/25 at 9:16 AM, revealed a neon pink sign on the inside of the entrance/exit door. The sign reflected, DO NOT ASSIST ANYONE OUT OF FACILITY. The sign was printed in large black font and was posted at eye level. The door had a keypad and required a code to exit the door.</p> <p>Observations on 05/07/25 between 9:16 AM and 3:50 PM, revealed staff entering the code to allow visitors in or out of the facility at the main entrance. The buzzer sounded each time the door was opened. No observations of visitors entering the door code was made. Observations of other entrance doors revealed keypads in place and DO NOT ASSIST ANYONE OUT OF FACILITY signs displayed.</p> <p>An observation on 05/07/25 at 10:00 AM, of the video surveillance from 04/18/25, revealed footage labeled Hall 400. Resident #1 opened her room door and looked into the hallway. She looked to the right, the left, back to the right, then back to the left. She stepped out into the hall and walked out of view of the camera. The resident was wearing long pants and a long-sleeved top. The next camera view was labeled Front Lobby. A person, identified as a family member, not related to Resident #1, was seen walking through the lobby to the front door. Resident #1 was observed as she entered the lobby. She adjusted the strap of her purse over her shoulder. She walked toward the front door. The family member was observed as she entered the code to open the front door. The family member exited the door, turned, and saw Resident #1 walking toward the door. The family member held the door open, and Resident #1 walked out. The next camera view was labeled, Parking Lot. Resident #1 was observed as she walked across the parking lot away from the facility. The time stamp reflected 04/18/25 at 9:52 PM. The video ended when the resident reached the end of the parking lot.</p> <p>A voice message was left 05/07/25 at 10:45 AM, which requested a return call from Resident #1's family member. A return call was not received prior to exit from the facility.</p> <p>During a telephone interview on 05/07/25 at 11:10 AM, an officer from the (city) Police Department provided the location where Resident #1 was picked up by EMS on the morning of 04/19 /25 at 1:45 AM. A mapping website reflected the location was 1.6 miles from the facility. The officer stated he did not participate in the search for the resident because it happened on the night shift. He stated he was able to review the report from the officer who participated in the search.</p> <p>During an interview on 05/07/25 at 1:16 PM, LVN A stated she had received training on elopement recently. The training included identifying risk and preventing elopement. She did not remember the exact date but knew it was after the recent elopement. She stated she did not work the day the resident eloped, and she did not recall any residents with exit-seeking behaviors. She stated if a resident was missing, staff would immediately initiate a search, complete a head count, and notify management immediately. LVN A reported recent training on ANE and named the ADM as the Abuse Coordinator.</p> <p>During an interview on 05/07/25 at 1:19 PM, MA B stated she did not recall ever seeing Resident #1 standing near exit doors or trying to get out of the facility. She stated she had training on ANE and Elopement a few weeks ago. She stated since that training, the door codes had changed, and they were not allowed to give the new code to family members. She stated the family members were understanding once the reason for the change had been explained to them. MA B stated if a resident was missing, they conducted a search, completed a head count, and notified the charge nurse immediately. MA B was able to describe types of abuse and the need to report any abuse immediately.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/07/25 at 1:26 PM, a visiting FM stated staff open the door for her when she entered and exited the facility. She stated she had not been given the code for the doors. She stated it had not been a problem as staff had been available to assist her at each visit.</p> <p>During an interview on 05/07/25 at 1:28 PM, LVN C stated she had recent training on elopement and not giving the door code to visitors. She stated they in-service included training on completing the elopement assessment on admission, frequent rounding, watching for residents exit-seeking, and not giving out the code for the doors. She stated staff assisted family and other visitors in and out of the building. She stated she had received frequent in-services on ANE, spoke to the policy, and named the ADM as the abuse coordinator.</p> <p>During an interview on 05/07/25 at 1:31 PM, the DON stated Resident #1 had been assessed on admission and she was not an elopement risk. She stated the resident was admitted for short term therapy to gain strength after her hospitalization . The DON stated she drove to the facility as soon as she was notified, around 12:30 AM, that the resident was missing . She stated the facility was thoroughly searched and a nurse had searched the perimeter. The administrative staff went out in teams and searched for the resident. She stated she and the dietary manager found Resident #1 near her home. She stated the Resident #1 allowed a partial assessment and the resident made it known that she did not want to return to the facility. The DON stated the resident agreed to go to the hospital to be evaluated after she reported some shortness of breath. She stated the police officer at the scene call for EMS who transported the resident to the hospital.</p> <p>During an interview on 05/07/25 at 2:26 PM, the ADM stated he expected residents were treated with dignity and respect. He stated they tried everything in their power to prevent elopements. He stated he was called just after midnight after the resident was missing. Staff told him they had searched the facility and ensured all other residents were present. He stated, once at the facility, he watched the video and saw the resident had been let out of the building by a visiting family member. He stated a family member of Resident #1 provided addresses for local friends and the resident. The police were notified and assisted in the search. The ADM stated the DON and DM had found the resident about a block from her house. He stated EMS took the resident to the hospital for evaluation. Upon return to the facility, he changed the codes to the doors and staff were instructed not to give the new code to family or visitors. He stated signs were created and placed at each exit. He stated they initiated in-service training on elopement, resident rights, and visitations. The ADM stated they did not have a locked unit and they did not use a Wander guard system.</p> <p>During an interview on 05/07/25 at 3:00 PM, CNA D stated she did not remember Resident #1. She stated she had been trained on Elopement and Resident Rights recently but did not remember the date of the training, about 3 weeks ago. She named the ADM as the abuse coordinator and stated any abuse must be reported immediately. She stated frequent rounding and knowing where the residents were was important to prevent elopement. She stated the door code was not to be given to visitors .</p> <p>Review of an in-service dated 04/19/25 and initiated by RN E then continued by the DON, ADON, and ADM, reflected staff were in-serviced on identifying high risk for elopement, understanding elopement, prevention of elopement, and adding to QAPI.</p> <p>Review of an in-service dated 04/19/25 and initiated by RN E then continued by the DON, ADON, and ADM, reflected staff were in-serviced on Resident Rights.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Ad Hoc QAPI meeting agenda, dated 04/21/25, reflected the ADM, DON, SW, and MD participated.</p> <p>Review of eight resident medical records reflected Elopement Assessments were all current. Residents who had been in the facility more than 90 days had Elopement Assessments completed quarterly.</p> <p>Review of the facility's Elopement Policy, dated Qtr 3, 2018, reflected the following:</p> <p>Staff shall investigate and report all cases of missing residents.</p> <p>4. If an employee discovers that a resident is missing from the facility, he/she shall:</p> <p>a. Determine if the resident is out on an authorized leave or pass;</p> <p>b. If the resident was not authorized to leave, initiate a search of the building(s) and premises;</p> <p>c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., Emergency Management, Rescue Squads, etc.);</p> <p>d. Provide search teams with resident identification information; and</p> <p>e. Initiate an extensive search of the surrounding area.</p> <p>5. When the resident returns to the facility, the Director of Nursing Services or Charge Nurse shall:</p> <p>a. Examine the resident for injuries;</p> <p>b. Contact the Attending Physician and report findings and conditions of the resident;</p> <p>c. Notify the resident's legal representative (sponsor);</p> <p>d. Notify search teams that the resident has been located;</p> <p>e. Complete and file an incident report; and</p> <p>f. Document relevant information in the resident's medical record.</p> <p>Review of the facility's Resident Rights Policy, revised February 2021, reflected the following:</p> <p>Employees shall treat all residents with kindness, respect, and dignity.</p> <p>l. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>a. a dignified existence;</p> <p>(continued on next page)</p>		

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