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Form Approved OMB
No. 0938-0391

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 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	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.

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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** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #1) The facility failed to ensure an egress door was adequately secured or Resident #1 was supervised closely enough to prevent her from eloping from the facility on 02/14/2026. The noncompliance was identified as PNC. The IJ began on 02/14/2026 and ended on 02/16/2026. The facility had corrected the noncompliance before the survey began on 02/19/2026. This failure placed residents at risk of injuries due to falls, motor vehicle accidents, or exposure to the elements. Findings included:Record review of the undated face sheet for Resident #1 reflected an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included vascular dementia with mood disorder (decline in brain function/cognition due to poor blood circulation), generalized anxiety disorder, major depressive disorder, insomnia (trouble sleeping), difficulty walking, unsteadiness on feet, and history of falling. Review of the quarterly MDS assessment dated [DATE] reflected a BIMS score of 6, indicating a severe cognitive impairment. The MDS reflected Resident #1 had not exhibited wandering behaviors in the 7-day lookback period. The MDS reflected she used a wheelchair for ambulation and required substantial assistance, once seated in wheelchair, to wheel at least 150 feet in a corridor or similar space. Review of the care plan for Resident #1 reflected the following with respective dates: 07/22/2025Focus: Impaired physical functioning r/t debility, cognitive impairment. Goal: Will remain well groomed, dressed, and assisted by staff as needed through the next review date. Intervention: Walking - n/a; [NAME] Wheelchair - independent.07/22/2025Focus: I am visually impaired, but has (sic) glasses. Goal: will use appropriate visual devices (i.e., glasses) to promote participation in ADLs and other activities. I have glasses that I use everyday. Intervention: I will be oriented to environment and placement of things in the room.02/15/2026Focus: Resident is at risk for elopement related to cognitive impairment, impaired safety awareness, and ability to ambulate independently, wandering behaviors, elopement risk assessment score as evidenced by HISTORY OF ELOPEMENT EVENT. Goal: WILL NOT WANDER OR ELOPE INTO AN UNSAFE ENVIRONMENT THROUGH NEXT REVIEW DATE. Interventions: 1:1 monitoring as ordered. ELOPEMENT ASSESSMENT PER FACILITY PROTOCOL; NOTIFY MD AS NEEDED. Requested repeat UA. Seeking alternative placement due to increased elopement behaviors. WANDERING/ELOEPMENT: ASSESS FOR UNMET NEEDS (PAIN, HUNGER, TOILETING, BOREDOM). WANDERING/ELOPEMENT: ASSESS FOR ACUTE CHANGES IN CONDITION CONTRIBUTING TOBEHAVIORS (UTI, INFECTION, ANXIETY, FEAR, MEDICATION CHANGES). TREAT UNDERLYING CAUSE IF ABLE. WANDERING/ELOPEMENT: DOCUMENT AND MONITOR BEHAVIORS EVERY SHIFT WHEN ACTIVE EXIT SEEKING BEHAVIORS ARE PRESENT. COMMUNICATE BEHAVIOR CHANGESTO NURSE PROMPTLY. WANDERING/ELOPEMENT: INCREASE MONITORING WHEN RESIDENT DEMONSTRATES NEW OR INCREASED EXIT SEEKING BEHAVIORS AND CANNOT BE REDIRECTED. WANDERING/ELOPEMENT: PROVIDE MEANINGFUL AND ENGAGING ACTIVITES TO REDIRECT RESIDENTWHEN WANDERING/EXIT SEEKING BEHAVIORS (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	procedures for missing residents and general abuse and neglect prevention. She stated they were informed they would be doing residents head counts every hour instead of every two hours. A telephone interview with LPN P was attempted on 02/19/2026 at 1:50 PM. A voicemail was left but not returned. During an interview on 02/19/2026 at 1:52 PM, the PCP stated he had been notified of Resident #1's elopement and had ordered one-to-one supervision. He stated he had not been directly notified about Resident #1's increased wandering behavior prior to the elopement, but as he understood it, the incident happened suddenly. He stated he rarely came to any of his facilities, but other physicians and nurse practitioners visited frequently. He stated the facility was very good about communicating with him. During a telephone interview on 02/19/2026 at 03:17 PM, CNA L stated she had worked with Resident #1 on 02/14/2026. She stated she was employed by a staffing agency and not the facility, but had worked at the facility before. She stated during dinner on 02/14/2026, Resident #1 was at the table finishing her milkshake, and the kitchen staff were present. CNA L stated she was busy and walked through the dining room approximately 6:00 PM and did not see Resident #1. She stated that CNA I had told her they would need to put Resident #1 to bed right away after she finished dinner because Resident #1 liked to wander. CNA L stated the significance of Resident #1 being gone from the dining table did not dawn on her due to being so busy at that hour. She stated she was aware the power had gone out briefly earlier in the day and the door codes had to be reset. CNA L stated she was not aware that the egress door between the dining room and Resident #1's room was unsecured, because she had not been a part of checking the doors for security after the power outage. She stated she found out afterward the door was unsecured when she and the charge nurse went to the door and it swung open and would not latch closed. She stated the charge nurse posted her (CNA L) at the door until someone arrived to fix the problem. She said she thought it was around 8:00 PM when the MAINT D arrived and began working on the door. She stated the ADM and the DON came to the facility that night, and she was instructed to do headcounts of all her residents every hour instead of every two hours. She stated she had not been back to the facility since then. During an interview on 02/19/2026 at 03:56 PM, MA G stated she had worked as the medication aide for Resident #1 on 02/14/2026. She stated Resident #1 had been wandering about the building earlier in the evening, before dinner. She stated she had found Resident #1 on the 400 hall, brought her to dinner, and then gave her medications at 5:56 PM while she was in the dining room by herself, finishing her dinner. She staed she was not aware of anything that happened after that, because she left for the day. She stated the next day, they were called in to a meeting with the ADM and received in-servicing on door checks, door security including how to identify a door that was unsecured, signs that a resident might elope, elopement/missing resident procedures, and abuse/neglect. During an interview on 02/19/2026 at 03:34 PM, CNA P stated she worked the 2 PM-10 PM shift at the facility and had received in-servicing recently related to the elopement of Resident #1. She stated they were told Resident #1 would be on one-to-one supervision and was asked to pick up shifts for that. She stated they were trained on the abuse and neglect procedure, how to notice signs of elopement, what to do if there was a missing resident, resident rights, and door security. During an interview on 02/19/2026 at 04:14 PM, the MAINT S stated he came to the facility after Resident #1's elopement, but the MAINT D was already there, so he left the building. He stated he came back on 02/16/2026 and helped install the octagonal red alarms the facility bought for extra security to the door. He stated he had written out a request for a wander guard system. He said he had the email request but was not sure if the request had been approved by corporate yet. During a telephone interview on 02/19/2026 at 04:23 PM, LPN E stated she worked 6 PM to 6 AM and had received in-servicing a few days prior (did not recall exact date but it was a day or two after the (continued on next page)

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 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Nursing and Rehabilitation Center	1501 S Main St Lockhart, TX 78644

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	elopement) on elopement procedures, Resident #1 and her exit-seeking and one-to-one supervision, making sure the doors were all secured every shift, rounding on all residents each hour, and abuse/neglect/exploitation. During an interview on 02/19/2026 at 04:25 PM, RN A stated they were checking doors and all residents each hour. She stated she had several in-services and other than one-to-one supervision for Resident #1, it was not new information to her. She stated the information was on elopement procedures, door security, abuse and neglect, and residents who were exhibiting wandering behaviors or were at risk for elopement. During an interview on 02/19/2026 at 04:42 PM, the DON stated she received a call from LPN C that Resident #1 was found by a community member and brought back to the facility on [DATE] after getting out. The DON stated she went to the facility and they checked all the doors and found the one door closest to Resident #1's room was not secure. She stated Resident #1 had been declining cognitively and was not as safety aware as she had been, so the DON had tried to engage the FM in decisions to protect Resident #1's safety. The DON stated she had suggested that Resident #1 be moved closer to the front of the hall where she would be near to the nurse's station instead of at the very end of the hall, but her FM declined that suggestion. She stated this conversation with the FM happened the day before the elopement. She stated Resident #1 had chronic and frequent UTIs and was tested for a UTI the day after the elopement and received a positive result, so that could have also played a part in her unusual behavior. The DON stated the failure was a combination of the malfunctioning egress door and Resident #1's increased cognitive impairment. She stated the RCS had been at the facility all week and had in-serviced her and the ADM on procedures and best practices in a situation like this to make sure it never happened again. She stated Resident #1 was assessed and had no injuries after the incident. She stated they were investing in a wander guard system for the facility and would have Resident #1 on one-to-one supervision at the facility's expense until the wander guard was installed. She stated all residents received updated elopement risk assessments and revised care plans if applicable. She stated Residents #2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 each had their care plans updated. She stated she was in-servicing the entire staff and also had materials prepared for agency staff. She stated in-services were on door security, behaviors indicating risk of elopement, head counts once per hour, missing resident procedures, and abuse/neglect/exploitation. Observation and interview on 02/19/2026 at 04:55 PM, revealed a driveway extending from the back of the facility and exiting into the main road. The DON stated Resident #1 was found close to the area of th