STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675490	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Villa	1104 S William St Atlanta, TX 75551

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 - Some	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** 30527 Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 6 residents (Resident #1) reviewed for accidents. The facility did not prevent Resident #1 who had a history of wandering from leaving the facility unsupervised. On or about 07/28/2024, Resident #1 was found approximately 50 feet away from the entrance of the facility around 4:00 AM. The facility failed to ensure Resident #1 received adequate supervision to prevent elopement. The facility failed to investigate resident #1's three separate elopements that occurred in July 2024, October 2024, and January 25, 2025. The facility failed to put interventions in place to prevent Resident #1 from eloping. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 4:48 PM. on 01/30/2025. While the IJ was removed on 01/31/2025, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures could place residents at risk of accidents, injury, or death. Findings included: Record review of a face sheet dated 11/26/2024 indicated Resident #1 was [AGE] year-old female, admitted to the facility on [DATE], with diagnoses including transient cerebral ischemic attack (brief blockage of blood flow to the brain), pain, dementia (degenerative brain disease - loss of memory, language) and urinary tract infection. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS of 06 and was severely cognitively impairment. Resident #1's MDS indicated wandering behavior was not exhibited. Resident #1 required supervision for eating, maximal assistance for toileting, showering, dressing and personal hygiene. Resident #1 required touching and supervision for ambulation and transfers. (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 - Some	Record review of the care plan dated 06/19/2024 indicated Resident #1 experienced wandering with the interventions of clear pathways, avoid over stimulation and equipped with a device that alarms when wanders. Record review of the consolidated physician orders dated 01/01/2025 - 01/31/2025 indicated Resident #1 had an order for a wander guard with daily functional checks with a start date of 05/01/2024. Record review of the elopement assessment dated [DATE] indicated Resident #1 was a moderate risk for elopement with a score of 14. Record review of an elopement risk book titled Happy Feet kept at the nurses' station indicated Resident #1 was identified as an elopement risk. Record review of the facility's Incidents and Accidents Reports dated 06/01/2024 - 01/27/2025 did not indicate any elopements. Record review of Resident #1's chart did not indicate incidents of elopement, exit seeking behaviors, or notification to her family or physician regarding any elopements or exit seeking behaviors. Record review of unsigned progress note dated 07/29/2024 at 10:00 AM indicated Resident #1 was COVID positive and weak. Record review of progress noted dated 07/29/2024 at 09:30 PM signed by LVN N indicated Resident #1 was being sent to the emergency room per physician orders due to weakness. Record review of the schedule dated 07/27/2024 for 6 PM to 6 AM indicated the following: LVN K - 6PM - 6AM LVN B - 6PM - 6AM LVN E - 6PM - 6AM CNA A - 2PM - 6AM CNA F - 2PM - 6AM CNA G - 10PM - 3:30AM Record review of the wander guard bracelet daily checklist dated 07/2024 to 01/2025 indicated no issues. Record review of the alarm door battery monthly checklist dated 02/2024 - 01/2025 indicated no issues. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/28/2025 at 11:30 AM, Resident #1 said she got in trouble by the staff for going outside. Resident #1 said she could not remember when those incidents occurred, or which staff member got on to her for going outside of the facility. Resident #1 stated she did not want to talk about it and looked away from the surveyor. During an interview on 01/28/2025 at 11:35 AM, Resident #1's roommate said Resident #1 had gotten out of the facility at least three times that she could recall. Resident #1's roommate said she usually tried to get out at nighttime. Resident #1's roommate said Resident #1 would wait for someone to go out of the door and then she walked out behind them. Resident #1's roommate said she had seen the staff bring Resident #1 back to the room and put her to bed after she had been outside of the facility. Resident #1's roommate stated she overheard staff talking to Resident #1, when she was returned to the room. Resident #1's roommate said she was unable to recall the staff involved or the dates of those incidents, but it was more than a month ago. During a telephone interview on 01/28/2025 at 01:40 PM, Resident #1's family member stated they had not received any calls from the facility regarding incidents of elopement or exiting seeking behaviors. During an interview on 01/28/2025 at 03:36 PM, CNA A stated she had worked at the facility for over a year. CNA A said she worked the 2 PM to 6 AM shift. CNA A said Resident #1 got out of the facility and was found out in the grass by one of the kitchen aides when reporting to work between 4 AM or 5 AM. CNA A said that the kitchen aide had told one of the nurses that a resident was laying on the ground in the grass beside the parking lot when she entered the facility that morning. CNA A said she later saw LVN B assist Resident #1 to her room. CNA A said Resident #1 had ambulated with her rollator back to her room. CNA A said she always redirected a resident if they were too close to the doors. CNA A said if she had any difficulty with redirecting or felt like the resident's safety was in jeopardy, she would immediately report to the nurse. CNA A stated the nurses were responsible for the reports and notifying the family and doctor, but all staff were responsible for the safety of the residents. CNA A said communicating the residents' needs was very important, so the right care was given to the residents. During an interview on 01/28/2025 at 09:00 PM, an anonymous staff member stated Resident #1 had a significant change of condition on 07/29/2024, after it was reported she was found outside in the early hours of 07/28/2024 by staff. During a telephone interview on 01/29/2025 at 09:15 AM, the Transportation Aide stated she had completed the wander guard checks daily with the remotes to the doors and 3 days weekly of the resident at the doors. The Transportation Aide stated she took over checking the wander guard system sometime in July 2024 when the facility received the new upgraded system. The Transportation Aide stated there had been some issues when the upgraded system was installed because it would not stay programmed. The Transportation Aide stated the issue with the wander guard system may have occurred in July 2024. During an interview on 01/29/2025 at 09:45 AM, the Administrator stated he wanted to be clear that the facility had not had any elopement incidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 01/29/2025 at 10:15 AM, the Maintenance Supervisor stated when he checked the door alarms on the 200 hall, it alarmed when the door was opened but the alarm tuned off within 1 minute prior to deactivating it. The Maintenance Supervisor stated it appeared the red metal box of the alarm, which hung on the door, had been damaged, and he did not know how it was damaged. The Maintenance Supervisor stated the system was not working correctly, and that could result in an elopement. The Maintenance Supervisor said it could result in an elopement because the alarm could turn off before the staff were alerted a resident went out, and the resident leaving would go unnoticed. The Maintenance Supervisor stated the door alarm batteries are checked monthly. During a telephone interview on 01/29/2025 at 10:50 AM, LVN E stated she worked at the facility as needed. LVN E stated she had worked on 07/27/2024 on the 6 PM to 6 AM shift. LVN E stated around 4:30 AM - 5:00 AM, a female kitchen aide entered the facility and said, there was a resident outside lying in the grass. LVN E stated she and a male CNA followed the kitchen aide approximately 50 yards outside of the facility's entrance door to the left side of the building to Resident #1, who was lying in the grass. LVN E stated Resident #1 was lying in a grass area between the sidewalk and parking lot with the rollator slightly positioned on top of her. LVN E stated Resident #1 appeared confused but had no complaints of pain or any visible injuries. LVN E stated she left the two staff members with Resident #1 and went inside the facility to get LVN B. LVN E stated LVN B was Resident #1's nurse. LVN E stated she assisted LVN B and the male CNA to get Resident #1 off from the ground and back into the facility. LVN E stated at the beginning of her shift around 7:00 PM on 07/27/2024 , she had noted Resident #1 was in the hall. LVN E stated LVN B reminded Resident #1 that she was COVID positive and walked Resident #1 back to her room at that time. LVN E stated she could not identify the male CNA by name or the kitchen staff aide because it was a large facility and she had only worked on an as needed basis. LVN E recalled that the male CNA identified Resident #1 once they were outside. LVN E remembered the male CNA stated Resident #1 did not reside on the hall he was working, and he was not familiar with her baseline status. LVN E stated Resident #1 had on the wonder guard bracelet. LVN E stated no alarms had gone off in the facility. LVN E said the alarms were very loud and noticeable. LVN E stated the nurses had a key and the key had to be inserted and the code entered to turn the alarms off once activated. LVN E stated she offered to help LVN B, but she declined her offer. LVN E stated it was important to document the incident in the resident's chart and complete an incident report, as well as report the incident to the DON, family, and physician. LVN E said the importance of following the protocol was for continuity of the resident's care. LVN E stated the incident would need to be investigated to determine how the resident exited the facility, and new interventions should be updated to be specific for that resident. LVN E stated she had not completed the incident report regarding Resident #1 because LVN B stated she would take care of it. During an interview on 01/29/2025 at 11:57 AM, Kitchen Aide C stated she had worked at the facility for approximately three years. Kitchen Aide C stated she arrived at work on a Sunday around 5:00 AM when Resident #1 was ambulating with a rollator on the sidewalk with staff members. Kitchen Aide C stated she recognized Resident #1 from previously working the halls. Kitchen Aide C said that Kitchen Aide D told her she had found Resident #1 out by the parking lot when she arrived at work. Kitchen Aide C could not remember the exact date but recalled it was on a Sunday several months back. Attempted telephone interview on 01/29/2025 at 12:15 PM to Kitchen Aide D. A voice message was left requesting a call back. (Kitchen Aide D was no longer employed at the facility.) During an interview on 01/29/2025 at 12:17 AM, the Administrator stated there are no recorded videos of the facility. The Administrator stated the videos record over and over after a 24-hour period. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview and observation on 01/29/2025 at 03:35 PM, the maintenance supervisor tripped the alarm on hall 200 by opening the door. The alarm remained on until the key and code were entered appropriately. Attempted telephone call on 01/29/2025 at 06:46 PM to Kitchen Aide D. A voice message was left requesting a call back. (Kitchen Aide D was no longer employed at the facility.) During a telephone interview on 01/29/2025 at 06:49 PM, CNA F stated he heard the kitchen aide (he did not know the kitchen aide's name) tell LVN E that a resident was lying outside on the ground. CNA F stated he and LVN E followed the kitchen aide outside and found Resident #1 lying on the grass with her rollator toppled over her. CNA F stated LVN E assessed the resident and then went back into the facility and got LVN B. CNA F stated they assisted Resident #1 off the ground. CNA F stated Resident #1 walked back to the facility using her rollator. CNA F stated Resident #1 seemed confused but was not injured. CNA F stated LVN B took Resident #1 back to her room. Attempted telephone interview on 01/29/2025 at 07:00 PM to Kitchen Aide D. A voice message was left requesting a call back. (Kitchen Aide D was no longer employed at the facility.) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/29/2025 at 07:35 PM, LVN B stated she had worked at the facility for 2 years on the 6 PM to 6 AM shift. LVN B stated she had never had a resident leave out of the facility or exit seek. LVN B stated the alarms may activate but the residents turned away from the door or she had redirect them to another activity, but the residents had never gone outside of the facility. LVN B stated if a resident went outside of the facility that would be considered an elopement. LVN B stated if a resident got outside the facility that could result in serious harm even death due to being hit by a vehicle in the parking lot or the roadway. LVN B stated if a resident left out of the facility or exhibited exit seeking behaviors, it would be documented in the resident's chart, an incident report would be completed, and the family and physician would be notified. LVN B stated the purpose of documenting incidents and notifications was so the physician and the facility staff would know how to take care of the resident appropriately. LVN B said an elopement should be reported to the DON for further investigation to prevent the situation from happening again. LVN B stated Resident #1 had not exhibited exit seeking behaviors. LVN B stated Resident #1 had not been outside the facility. LVN B denied any incidents of Resident #1 being outside of the facility for an undetermined time or being found outside by the kitchen staff. LVN B denied she had assisted LVN E or CNA F when Resident #1 was found outside in the parking lot. LVN B stated Resident #1 had never gone outside of the facility without their knowledge. LVN B stated she had no idea why the other staff reported her involvement with Resident #1 outside of the facility because she had no recollection of that situation. LVN B stated that one time Resident #1 had gone outside the facility but only to the picnic table. LVN B stated this incident had occurred in the month of October 2024 around the time she was doing morning rounds at 6:00 AM. LVN B stated Resident #1 had used the door on hall 5 to exit the facility and had sat down at the picnic table when she and the CNA reached her. LVN B said she and other staff had followed see Resident #1 exit the building and had followed her out. LVN B stated she never lost sight of Resident #1 and she was approximately 10 steps away from the door on hall 5. LVN B stated CNA G had assisted her to get Resident # 1 back into the building to her room. LVN B said she placed Resident #1 into her bed after she changed her socks because they were covered in grass, washed the mud from her legs, combed out Resident #1's hair because it was wet, and changed her gown because the bottom of it was soaked. LVN B stated she had filled out an incident report and documented in Resident #1's chart and notified her doctor and family member. LVN B was unable to locate the documented incident report or documentation in Resident #1's chart regarding the incident. LVN B stated she may not have documented anything because she was exhausted and needed to get home for sleep so she could return for the following night shift. LVN B said Resident #1 was fine, so there was really not anything to report anyway. During an interview on 01/29/2025 at 08:15 PM, CNA G stated he had not assisted LVN B with Resident #1 in changing her gown or socks after Resident #1 had been outside of the facility. LVN B stated he had no information about that incident. CNA G stated he was not at work when that incident occurred. CNA G stated that on Saturday, January 25th, 2025, Resident #1 had opened the door on hall 200 and had gone out the door. CNA G stated that the alarms went off. CNA G said he saw Resident #1, LVN B, and LVN H at the corner of the building about 5 steps outside the door leading Resident #1 back into the building. CNA G stated that incident occurred around 7:00 PM, and he had spent the remainder of his shift until 10:00 PM on 1:1 with Resident #1 per the instruction of LVN B. CNA G stated LVN B placed Resident #1 back in the bed. CNA G said Resident #1 had not attempted to get out of bed during the 1:1 care. CNA G said he could not think of any times he had personally been involved with Resident #1 eloping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and interview on 01/29/2025 at 08:35 PM, LVN B stated if CNA G was not who helped her with Resident #1 when she sat at the picnic table back in October 2024, she could not remember who had helped her. LVN B said she remembered Resident #1 at the corner of the building approximately 5 steps outside the door, when LVN B and LVN H had guided Resident #1 back inside the building. LVN B denied any 1:1 care provided by CNA G. LVN B stated Resident #1 was fine, and that incident was not considered exit seeking behaviors or elopement because she had been able to redirect Resident #1 and had never lost sight of Resident #1. LVN B stated Resident #1 was not hurt, and she was fine. LVN B stated she was sure she had notified Resident #1's family but guessed she did not document it. LVN B stated she should have documented the incident and notified the doctor and family. LVN B stated if she had not reported and documented the events, the doctor would not know Resident #1 required a more secured unit, which could cause potential harm to the resident. During an observation of the picnic table located outside of hall 500 approximately 10 ft. from the door, LVN B agreed there was no grass in the area only dirt and concrete. During an interview on 01/29/2025 at 09:15 PM, LVN K stated she had worked at the facility for 3 years. LVN K stated if a resident got outside the facility that would be considered an elopement. LVN K stated if a resident eloped, after she ensured the resident was safe, she would complete the required incident report, document in the resident's chart, notify the family, physician, and DON. LVN K stated it was important to document and report exit seeking behaviors and elopements to protect the resident and provide the most appropriate person-centered care to keep the residents safe. LVN K defined exit seeking behaviors as going to the door repeatedly, fiddling with the door handles, and window locks and setting off the alarms. LVN K defined elopement as requesting to go home, packing up their items, and getting out of the facility's door. LVN K stated if a resident eloped, the resident could suffer from physical injuries, falls, or being hit by car, or environmental injuries, heat or cold weather exposure. Therefore, reporting the incidents would result in an investigation to figure out how to prevent another occurrence of that nature. LVN K stated all the nurses at the facility regardless of shift, full- time or part time have a group chat for communication also. LVN K stated she could not recall receiving information in the group chat regarding Resident #1 being out of the building lying near the parking lot. LVN K said she worked on 7/27/2024 from 6 PM to 6 AM and was the charge nurse. LVN K said she did remember Resident #1 exited the facility and was found lying near the parking lot. LVN K said she vaguely recalled someone coming into the facility saying a resident was outside. LVN K said she could not recall any more details. During an interview on 01/29/2025 at 09:35 PM, CNA L stated she vaguely remembered someone had reported a resident outside the facility around 5:00 AM or 6:00 AM. CNA L stated she immediately verified that the residents on halls 100 and 400 were accounted for. She stated she had heard it was Resident #1, but she had not seen it for herself. CNA L stated she was not for sure of when it occurred. CNA L stated she could barely remember that incident. CNA L stated it was important to report to the charge nurse any exit seeking behaviors. CNA L stated if an elopement occurred, always ensure resident safety, then notify the nurse for assessments and reports to be completed. CNA L stated it was important to communicate the residents' required care to protect the residents from harm. Attempted telephone interview on 01/30/2025 at 09:50 AM to Kitchen Aide D. A voice message was left requesting a call back. (Kitchen Aide D was no longer employed at the facility.) Attempted telephone interview on 01/30/2025 at 09:53 AM to LVN M. A voice message was left requesting a call back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview 01/30/2025 at 11:45 AM, the ADON stated there had not been any incidents of elopement. The ADON stated if a resident attempted to leave or made the alarm go off those were considered exit seeking behaviors. The ADON stated if a resident opened the door, and stepped outside the facility that was considered elopement. The ADON stated both exit seeking behaviors and elopements should be reported, documented, and the family and doctor should be notified. The ADON said this communication helped ensure the safety and continuity of care. The care plan should be updated to accurately reflect the needs of the residents so the staff can provide appropriate interventions. The ADON stated Resident #1 wandered. The ADON stated she was not aware of any incidents involving exit seeking behaviors or elopements with Resident #1. During a telephone interview on 01/30/2025, the Medical Director stated that he nor his physician assistant had been notified recently of any elopements from the facility or of Resident #1 exhibiting exit seeking behaviors. The Medical Director stated he could not be for sure, but he thought he was notified of a resident that got out of the facility on hall 5 but that had been several months ago. The Medical Director stated he expected the facility staff to notify him of any types of elopements and of exit seeking behaviors. The Medical Director stated he also expected appropriate incident reports and documentation to be completed and investigated so that the residents' care plans could be updated to meet their needs. The Medical Director stated without that vital information, the resident was at risk of injury and harm, and he could not properly assess the residents' needs. During an interview on 01/30/2025 at 03:45 PM, the Administrator defined elopement as a resident that constantly asked and stated they wanted to go home - packing items, cannot be redirected, and she realized she was coming back to the facility. The Administrator stated he need more education and had some regrouping to do and stated the documentation should have been completed and reflected on the reports and in Resident #1's chart. The Administrator stated he was never told that Resident #1 had attempted to elope or exhibited exit seeking behaviors by attempting to leave out of the facility. The Administrator stated he stayed at the facility from 9 AM to 5 PM daily and found it hard to believe the reported incidents only occurred when LVN B was working. The Administrator stated he felt targeted by staff that had been terminated. The Administrator stated LVN B had been terminated. The Administrator stated Resident #1 was in the process of being transferred to a secure unit at this time. The Administrator stated if an elopement occurred or a resident was exhibiting exit seeing behaviors, it was important to properly document it, complete an incident report, start an investigation, and notify the family and the physician to ensure the residents' safety. An undated facility policy titled Nursing Policies and Procedures - Elopement/Missing Resident indicated: .To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing . (6) When the patient/resident is located, the charge nurse completes a head-to-toe assessment. The Social Service Designee assess the patient/resident for emotional distress The Administrator was notified on 01/30/2025 at 04:48 PM that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 01/30/2025 at 04:53 PM. The facility's Plan of Removal was accepted on 01/31/2025 at 08:12 AM. and included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Residents who have suffered or are likely to suffer a serious adverse outcome as a result of noncompliance. The failure to ensure that staff were following our elopement Policy had the potential to adversely affect all residents. Actions the facility will take. Regional Nurse provided in-service training to Administrator in person on the following topics. Inservice completed on 1/30/25 5:50 pm with Administrator, Director of nurses is currently outside of the country. Regional nurse will complete the same training before Director of nurses returns to next scheduled workday. Identifying an Elopement The importance of training staff to Document any elopements, Notifications required when elopements do occur. Importance of facility investigating each elopement and placing intervention to prevent reoccurrence which could result in injury or harm to the resident. The importance of facility elopement screening and assessments being completed accurate to determine wanderguard placement or potential secure unit placement. How to report an Elopement to HHSC. Completed at 5:50 pm In-services to all Staff were iniated1/30/25 @ 6:15 pm. Training will be conducted by administrator, ADONS and Regional nurses. Topics covered include Facility revised elopement policy. Policy addresses required assessments, documentation to complete and Notifications employees should contact. All in servicing will be completed by 1/31/25 @ 10am. No employee will be allowed to work until in servicing is completed. Elopement policy will be included in new hire training packets. All resident's elopement screens, and care plans were updated to ensure accuracy. Facility will follow elopement screen assessment guidelines for identifying level of risk. Facility screening tool provides a risk level numerical value based on key questions. All high-risk residents will be placed on Wander guard System. Audit and updates were completed by unit managers and ADONS (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675490	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Villa	1104 S William St Atlanta, TX 75551

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Initiated 1/30/25 @7pm to be completed on 1/31/25 @ 8am. All residents that are on wanderguard will be identified in a binder at the nurse's station, with resident demographics (face sheet) to identify each. Completed by Unit managers and ADONS Initiated on 1/30/24 Resident # 1 was assigned a designated sitter until secure unit placement can be arranged.1/30/25 @ 5pm Facility adopted a new Elopement policy on 1/30/25. The Updated policy clearly defines steps for employees to take during an elopement. The new policy directs staff on necessary notifications to make, and all documents to complete. Incident reports and medical record entry are covered as well On 01/31/2025 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During an observation at 01/31/2025 at 11:10 AM, Resident #1 had a 1:1 sitter outside her room door. Record review of in service dated 01/30/2025 provided by the Regional Nurse training to Administrator in person on the following topics. Identifying an Elopement The importance of training staff to Document any elopements, Notifications required when elopements do occur. Importance of facility investigating each elopement and placing intervention to prevent reoccurrence which could result in injury or harm to the resident. The importance of facility elopement screening and assessments being completed accurate to determine wanderguard placement or potential secure unit placement. How to report an Elopement to HHSC. Record review of In-services dated initiated on 1/30/25 provided by administrator, ADONS and Regional nurses. Completed by Topics covered include Facility revised elopement policy. Policy addresses required assessments, documentation to complete and Notifications employees should contact. All in servicing will be completed by 1/31/25 @ 10am. No employee will be allowed to work until in servicing is completed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Elopement policy will be included in new hire training packets. Record Review of all resident's elopement screens and care plans were updated to ensure accuracy. Audit and updates were completed by unit managers and ADONS. Record Review of wanderguard binder located at the nurse's station, with resident demographics (face sheet) to identify each was completed by Unit managers and ADONS. Record Review of new Elopement policy dated 1/30/25. The policy clearly defines steps for employees to take during an elopement which included: directs staff on necessary notifications to make, and all documents to complete. and Incident reports/medical record entry. Record Review of the QAPI Committee Review -committee meeting was completed on 01/30/2025. Interviews of nursing staff: 6 AM - 6 PM - ADON, ADON QQ, MDS Nurse, LVN H, LVN P, LVN Q, LVN R, LVN BB, LVN VV, HA KK, HA LL, HA MM, HA NN, MA S, MA T, CNA U, CNA V, CNA W, CNA X, CNA Y, CNA AA, CNA CC, CNA DD, HA EE, HA FF, HA GG, CNA HHH. Social Worker, Activity Director Assistant, Transport Driver, Maintenance Supervisor, Receptionist, BOM, Medical Records, Laundry Aide SS, Housekeeper UU, Kitchen Aide C, Housekeeper Supervisor, Dietary Aide DDD, Dietary Aide EEE, Dietary FFF, Dietary GGG, Assistant Cook, Dietary Supervisor. 6 PM - 6 AM - LVN K, LVN N, LVN TT, HA PP, HA OO, HA RR, CNA G, CNA L, HA RR, CNA WW, CNA XX, CNA Z, HA HH, CNA A, CNA CCC. During these interviews' staff were able to correctly identify steps to take in the event of an elopement per the facility's policy such as types of exit seeking behaviors, interventions for exit seeking behaviors, required reporting and to whom, documentation of incidents reports and resident chart including care plans, and notifications to the family and physician. On 01/31/2025 at 2:06 PM., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. On 01/31/2025 at 02:06 PM., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30527 Based on observation, interview and record review, the facility failed to maintain an effective pest control program so the facility was free from pests and rodents for 2 of 2 residents (Resident #1 and Resident #2) reviewed for pest control. The facility failed to maintain an effective pest control program to ensure the facility was free of roaches. This failure could place residents at risk for an unsanitary environment and a decreased quality of life. Findings included: 1.Record review of a face sheet dated 11/26/2024 indicated Resident #1 was [AGE] year-old female, admitted to the facility on [DATE], with diagnoses including transient cerebral ischemic attack (brief blockage of blood flow to the brain), pain, dementia (degenerative brain disease - loss of memory, language) and urinary tract infection. Record review of the comprehensive MDS dated [DATE] indicated Resident #1 had a BIMS of 06 and was severely cognitively impairment. Resident #1 required supervision for eating, maximal assistance for toileting, showering, dressing and personal hygiene. Resident #1 required touching and supervision for ambulation and transfers. Record review of Resident #1's care plan did not indicate an environment free of pests. 2. Record review of a face sheet dated 12/08/2021 indicated Resident #2 was a [AGE] year old male, admitted to the facility on [DATE], with diagnoses including, dementia (degenerative brain disease - loss of memory, language), anxiety (intense, excessive and persistent worry) and aphasia (a language disorder that affects a person's ability to communicate effectively). Record review of the comprehensive MDS dated [DATE] indicated Resident #2 had a BIMS of 11 and was moderate cognitive impairment. Resident #2 was independent for eating, supervision for toileting, and moderate assistance x one staff member for showering, dressing and personal hygiene. Resident #1 required moderate assistance for transfers and a wheelchair for mobility. Record review of Resident #2's care plan did not indicate an environment free of pests. Record review of Exterminator receipts for the months 10/2024 - 01/2025 for monthly preventive pest control completed. During an interview on 01/27/202 at 11:22 AM, CNA KKK stated she has worked in the facility for 3 months. CNA KKK stated she had seen roaches in the building from time to time. CNA KKK said housekeeping had a turnover and felt like the housekeeping was more efficient now. CNA KKK said some housekeepers were not getting all the food from under the beds. CNA KKK said the residents need a clean environment free of trash and bugs to prevent sickness. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/2025 at 11:30 AM, Resident #1 said she often saw roaches in her bathroom, crawling on the floor around her dresser, and in the window seal. Resident #1 said she did not like the roaches, and it was disgusting. Resident #1 said the floors were dirty often with food crumbs and dust. During an interview on 01/28/2025 at 11:35 AM, Resident #1's roommate said she always saw bugs crawling around on the floor and walls in her room. Resident #2 said the bugs were big and little. Resident #2 said she did not like the bugs. Resident #1's roommate stated the Maintenance Supervisor had been spraying weekly. During an interview on 01/28/2025 at 2:15 PM, the Maintenance Supervisor stated the exterminator had not made any recommendations written or verbally to regarding pulling furniture away from the walls and deep cleaning prior to spraying in heavy infested areas or sightings of roaches. The Maintenance Supervisor said all the staff were responsible for making sure there was a clean, safe environment for everyone at the facility. The Maintenance Supervisor stated housekeeping was responsible for cleaning the resident rooms. The Maintenance Supervisor stated the exterminator usually made rounds with him, the Administrator, or the Housekeeping Supervisor. The Maintenance Supervisor said the exterminator come to the facility on ce monthly and if needed in between. The Maintenance Supervisor stated the Administrator makes the call to setup extra exterminator visits. The Maintenance Supervisor stated some residents and staff have told him verbally they had seen roaches and he used the gel roach in the rooms. The Maintenance Supervisor stated any staff can place a request on the list that was hung on the refrigerator, and he would address that issue as soon as he could. The Maintenance Supervisor said he could not recall if he had told the Administrator about the roach complaints or sightings The Maintenance Supervisor stated he had only seen dead roaches. The Maintenance Supervisor stated he does not spray the resident's room because some resident's may have breathing issues. During an interview on 01/28/2025 at 3:51 PM, the Exterminator said he made monthly service calls for preventive pest control to the facility. The Exterminator stated he could not state that he had specifically told the Maintenance Supervisor or Housekeeping Supervisor to pull out furniture and deep clean prior to his arrival but that had always been a recommendation for problem areas. The Exterminator said he verbally informed maintenance to keep areas clean of debris. The Exterminator said it was important to keep the environment free of pests because it was the residents' home and it needed to be clean and for them to have a safe environment. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/28/2025 at 11:40 AM, the Director of Housekeeping stated she had worked at the facility as the director of housekeeping for the last three years. She stated she had seen some roaches this past week in the laundry area and there had been some roaches seen around in the storage room where the cleaning supplies was located. The Director of Housekeeping stated she lets the Maintenance Supervisor know so that he can spray the roaches. The Director of Housekeeping stated she does not always keep a log of the roach siting's. She stated she verbally tells the Maintenance Supervisor. The Director of Housekeeping stated that the exterminator comes to the facility monthly. The Director of Housekeeping stated she does not ever have any dealing with the exterminator during the visit. The Director of Housekeeping stated that was all handled by the Maintenance Supervisor. The Director of Housekeeping stated that sometimes the housekeeper aides report bugs in the resident rooms to her so they will complete a deep clean of that specific room. Then after the room was deep cleaned, she would let the Maintenance Supervisor know and he would spray the room and put out the glue traps. The Director of Housekeeping stated she had not every told the Administrator or the Maintenance Supervisor that there was a need for increased exterminator visits due to reported roaches by the housekeeping staff. The Director of Housekeeping stated she does not have a routine deep clean scheduling system in place for the house keepers to follow. The Director of Housekeeping stated she allowed the staff to work that out on their own. The Director of Housekeeping stated allowing the housekeepers to decide what to do may not be the most effective system because some housekeepers may not be do the work. The Director of Housekeeping stated she monitored the housekeeping staff occasional by area/room walk throughs. The Director of housekeeping stated it was important to have a clean, sanitary environment because this was the residents' home. During an observation on 01/29/2025 at 09:45 PM, big and small roaches scattered across Resident #2 sink area, wall, and the closet upon entering the room. There was approximately 10 - 15 roaches on the sink. There were approximately 5 roaches that varied in size that scurred up the wall. During an interview on 01/30/2025 at 10:00 AM, Resident #2 said he had been seeing a bunch of roaches in his clothes. Resident #2 stated he did not like the roaches and wanted the roaches gone. During an interview on 01/30/2025 at 03:45, the ADON said she saw roaches in the hall and the nurses' station on occasions. The ADON said the facility should be free of pests to prevent infections and environmental issues. The ADON said she expected housekeeping to sweep and mop daily to prevent food and debris accumulation which attracted pest/rodents into the facility. She said it was everyone's job to pick up and take out trash from the residents' rooms to decrease bugs. The ADON said food should be removed from rooms daily or wrapped tightly and securely to prevent cross contamination and infections caused by roaches. The ADON said some residents had a lot of items in their rooms which made it difficult to maintain a pest free environment. During an interview on 01/30/2025 at 4:30 PM, the administrator said he expected housekeeping to maintain the resident's room to be clean. The Administrator stated he was not aware of roaches in the facility, but it was a large community. The Administrator stated the Exterminator Company comes monthly. The Administrator said he expected to be able to eat off the floors at the facility as he would at his own home. The Administrator said the facility should be free of pest to prevent infections and promote dignity to the residents. Record review of the facility's policy dated 01/2020 titled, Pest Control Program, indicated .Effective pest control program is defined as a measure to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and