STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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(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** 27430 Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #4) reviewed for elopement. The facility failed to supervise Resident #4 while he was outside smoking. When the gate opened on 12/05/2024, Resident #4 was able to exit through the gate and leave the grounds. An Immediate Jeopardy situation was determined to have existed on 12/05/2024. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance on 12/05/2024 before the beginning of the survey. This failure could place residents at risk for serious injury, harm, impairment, or death. Findings included: Record Review of Resident #4's facesheet dated 12/10/2024 revealed that Resident #4 was initially admitted to the facility on [DATE] with a readmission on 07/20/2022. Resident #4 had a medical history of neuroleptic induced parkinsonism (condition that occurs when antipsychotic drugs cause parkinsonism like symptoms such as tremors and rigidity), dementia with behavioral disturbance (loss of thinking, remembering, and reasoning with behavioral changes including agitation, aggression, wandering, delusions, hallucinations, depression often impacting their quality of life), schizoaffective disorder bipolar type (is a rare mental illness that combines schizophrenia symptoms with bipolar disorder symptoms of highs and lows), amnestic disorder (memory loss), schizophrenia (mental health condition that affects everything from how you think to how you feel and behave), anxiety disorder (feeling of fear, dread, and uneasiness), mild intellectual disability (deficits in intellectual functions pertaining to abstract/theoretical thinking), extrapyramidal and movement disorder (a group of movement disorders that CNA occur as a side effect of certain drugs particularly antipsychotics), ataxia (impaired coordination, CNA be due to damage to brain, nerves, or muscles), borderline intellectual functioning (difficulty adapting to changes or learning new skills), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #4's MDS dated [DATE] revealed, Section C- Cognitive patterns revealed a BIMS score of 00 which indicated Resident #4 had a severe cognitive impairment. (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	Record review of Resident #4's care plan dated 07/22/2019 revealed focus: **MENS SECURE UNIT** Resident #4 is at risk for wandering due to cognitive loss and has exit seeking behavior related to parkinson's and dementia. He currently resides on the secured unit related to high risk of elopement. Revision on 07/13/2023. Goals: Resident #4 will not leave facility unattended through the review date. Date initiated 07/22/2019, revision on 10/31/2019, target date 12/29/2024. Interventions/Tasks: Assess for fall risk 11/14/2019. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Date initiated 11/14/2019, revision on 11/14/2019. Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it include the need for exercise? Intervene as appropriate. Date initiated, 07/22/2019. If Resident #4 is exit seeking, stay with him, and notify the charge nurse by calling out, sending another staff member, call system, etc. Date initiated 07/22/2019, revision 08/08/2019. Monitor for fatigue and weight loss. Date initiated 07/22/2019. Monitor for resident messing with his window in his room. Date initiated 10/10/2020. Resident #4 resides on the male secure unit. Date initiated 01/02/2020. Resident #4 will reside in the secure unit. Date initiated 12/06/2024. Focus: **Smoker Alert** Resident #4 is a smoker. Safe smoking assessment completed; Resident #4 able to safely smoke supervised. Smoking materials to be kept at the nurses station. Date initiated 7/22/2019, revision 12/06/2024. Goal: Will smoke in designated areas without occurrence of injury of the next 90 days. Date initiated 07/22/2019, revision on 10/31/2029. Target Date 12/29/2024. Interventions/Tasks: 1. Perform smoking assessment according to facility policy. Date initiated 08/06/2019. 2. Explain/Show where designated smoking areas are, and smoking times-repeat as needed. Date initiated 08/06/2019. 3. Monitor when smoking to assure resident safety. Date initiated 08/06/2019, revision on 12/06/2024. 4. Keep all smoking materials at nurses station. Date initiated 08/06/2019. 5. Gather all smoking supplies after smoking time is completed, he saves his cigarette butts to take to his room, assist him in disposing of them properly. Date initiated 10/23/202, revision 12/06/2024. Focus: Actual elopement or elopement attempt. Resident #4 was confused and wandered outside the facility unattended. Dated initiated 12/05/2024, revision on 12/06/2024. Goal: Will remain safe in the facility with no further elopements or elopement attempts, unless accompanied by staff or other authorized person through review date. Date initiated 12/06/2024. Target date 12/292024. Interventions/Tasks: Directly supervise resident while smoking. Date initiated 12/06/2024. Provide structural activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Date initiated 12/05/2024. Distract Resident #4 from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books. Date initiated, 12/05/2024. If Resident #4 is exit seeking, stay with the resident, and notify the charge nurse by calling out, sending another staff member, call system, etc. Date initiated 12/05/2024. Record review of Resident #4's elopement risk assessment dated [DATE] reveals Resident #4 is an elopement risk with a score of 25 out of 28. Elopement risk assessment dated [DATE] revealed a score of 27 out of 28 which reveals elopement risk. Record review of Resident #4's safe smoking assessment dated [DATE] revealed: A. Evaluation: 6. Resident #4 is unable to enter door code to get to designated smoke area. B. Summary: 2. This resident requires direct supervision while smoking. 5. Care Plan up to date or updated. Safe smoking assessment dated [DATE] revealed: A. Evaluation: 6. Resident #4 resides on the secure unit and is unable to access it independently. 12. Trouble using fine motor skills. B. Summary: 2. This resident requires direct supervision while smoking. 4. All smoking materials will be kept at the nurses station. 5. Care plan up to date or updated. 6. The evaluation has been discussed with the resident. (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 progress notes for Resident #4 dated 12/05/2024 revealed: Event- Elopement/Attempted: Blood pressure 146/74, Temperature 97.8, Pulse 81, Respirations 22. Door exited: smoke door on D Hall. How long missing: unknown. Where was the resident discovered: off campus. Code Orange was initiated. Injuries: No. Cognition/Behavior at time of event: Cognitive impairment, paces, wanders. CNA's alerted nurse that resident was outside smoking and is now missing. Initial Treatment/New Orders: No. Resident Statement: I went for a walk. Physician and family notified. Interventions: Resident #4 placed back on the secure unit. During an interview on 12/11/2024 at 8:55 AM, the ADM stated that on Tuesday 12/03/2024, the facility became aware that the secured door on Hall A was not locked. The ADM reported that she called the repair company at that time, and they arrived that evening. ADM stated that the repair company was able to remotely tell them what to do to get the door back locked and secure. The repair company came back on Wednesday 12/04/2024 to continue to work and troubleshoot the problem. On Thursday 12/05/2024, ADM stated that the repairman was in her office at the time of the event. ADM stated that the worker was telling her that everything was secure at this time, but they would have to make arrangements for staff to monitor the Chapel door and two gates that evening because he was going to have to leave that circuit disengaged, due to him having to wait on a part that was being shipped. The worker reported that the Chapel Door circuit was losing voltage and affected two gates. During their conversation, RN called a Code Orange and reported that Resident #4 was missing. ADM reported that there were three staff on the unit when the incident happened. Resident #4 is the only resident that smokes on Hall D secured unit. The CNA A reported that the gate was closed when she let Resident #4 go out. ADM reported that she went to check the gate and reported that when it was disengaged it swung open. ADM stated that the Code Orange was called at 3:40 PM and the resident was located at 3:54 PM. ADM reported that HR located the resident in an alley, approximately a half a mile from the facility. ADM reported that the repair company basically replaced the whole system. ADM stated they had staff at the facility all weekend monitoring the doors and gates, and that she still had staff checking the doors, stating that she was no longer just going to rely on the system. ADM stated that the facility completed elopement assessments on every resident. ADM stated they had also changed their smoking policy to all residents have to have direct supervision when smoking. During an interview on 12/11/2024 at 10:00 AM, RN stated that on 12/05/2024 that she entered Hall D Secure Unit to check on the residents and to see if the CNA's needed anything. RN stated that when she got back there she sat down by CNA B, and then CNA A and HA came in from outside. RN stated that when HA was leaving she asked her to check on a resident that she thought was sick, and CNA A was checking on another resident that was up without assistance. RN stated she left the unit at that time, then a few minutes later, RN went back to the unit to tell CNA A and CNA C to get some clothes ready for a resident they were going to send out. RN stated around 3:40 PM that CNA C notified her that while she was on break, that one of the CNA' let Resident #4 go out and smoke, and now they cannot find him. RN stated she immediately called a Code Orange and made assignments. RN stated that she had not seen Resident #4 outside, and the staff did not report to her that he was outside. RN stated she thought CNA A and HA had just gone out to vape on their own. RN stated when they got Resident #4 back to the facility, that she completed a full head-to-toe assessment with no injuries noted. RN stated that Resident #4 reported he had just gone for a walk. RN stated she notified the family and reported that they were happy he was able to go for a walk and hoped he had enjoyed it. RN stated that they had immediate in-services, and now all smokers have to be directly supervised, and the care plans have been updated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 10:53 AM, HR stated that when she heard the Code Orange, she left her office to see who it was. HR stated after checking around the facility that she got in her car. HR stated that she knew Resident #4 did not like commotion or being around a lot of people and did not think he would stay around the main roads. HR stated that she drove around the back of the facility, where there is an open field that leads to a remote residential/business area. HR stated that she located Resident #4 shuffling down an alley. HR asked Resident #4 if he wanted to get in the car and go for a ride. HR stated that Resident #4 stated no and then swung a hand in a downward motion, indicating for her to go away. HR stated that she called the ADM who came to the area. HR stated that ADM got out and went to talk to Resident #4, asking him if he wanted to get a hamburger and a milkshake, Resident #4 stated he did. HR stated they were able to get him in the car, and they went to the drive through at a fast food establishment. HR stated that Resident #4 just wanted a coke. HR stated that Resident #4 indicated he was tired when they asked him how he was. HR stated that she googled the location, and it was 1.2 miles driving, but Resident #4 was probably only about half a mile the way he went. HR stated the staff have a secure app on their phones for communication, and notifications started coming in immediately. HR revealed that she had been in-serviced on the Code Orange, Elopement Protocol, and Supervised Smoking. Observation on 12/11/2024 at 11:20 AM, HR accompanied me to the main smoking area that is off of the main dining room. The Chapel is in the back left corner of the main dining room. HR had to put in the code to the side door for us to enter the smoking area. From the back of the fence, the gate to Unit D secured smoking area was able to be visualized and was closed. There is a large vacant field behind the facility, which leads to a residential/business section. HR verbalized and pointed out the road she was on while looking for Resident #4. During an interview on 12/11/2024 at 12:20 PM, the ADON stated the facility has been doing a lot of education and follow-up. ADON stated that CNA A is a brand new CNA. The ADON reported that CNA A got called away to assist with another resident. ADON stated that the department heads were at the facility all weekend checking doors and the gates. ADON also reported that facility staff are continuing to check the doors to be sure they are secured. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 12:51 PM, CNA A stated that she has been certified for about a month and a half. CNA A stated that her residents are like her family, and that she was so glad that Resident #4 was not hurt. CNA A stated that she had just returned from her break, and that her partner, CNA C then left the unit for her break. CNA A stated Resident #4 was wanting to go smoke, but stated she did not have a lighter, then HA came on the unit and CNA A asked her if she had a lighter. CNA A stated that HA left the unit to find a lighter, and when she got back, CNA A asked HA if she wanted to hit her vape before she left. CNA A stated they went outside, and she lit Resident #4's cigarette. CNA A stated that Resident #4 likes to walk over and stand at the turtle sanctuary that is in the back corner of the secured smoking area. CNA A stated that she and the HA were standing by the door, then HA stated she needed to leave. CNA A asked Resident #4 if he was ready to come in, and he said he was not ready. CNA A stated that she told Resident #4 to come to the door when he was ready to come in, and that she would be watching for him. CNA A stated she knows the gate was closed when they were outside. CNA A stated that when they went back in, that HA was leaving and hollered at her to come help with a resident that was up without assistance. CNA A stated that when she heard that, it was just instinct to run to go assist so that resident did not fall. She also reported that HA had notified RN that she was concerned that another resident needed to be checked because HA thought he was sick. CNA A stated that after they got that resident in bed, she heard another resident holler out. CNA A stated she had to go assist him or he will go to the bathroom in the floor. CNA A stated by that time CNA C had returned from her break, and that the RN asked them to get some clothes packed for a resident they were going to send out. CNA A stated that when they were in that resident's room getting clothes packed, she looked out the window and did not see Resident #4. CNA A stated that she figured Resident #4 was at the door ready to come in, but when she got to the door, he was not there, and the gate was open. CNA stated she went out and looked out the gate and did not see him. CNA A went inside and told CNA C that she could not locate Resident #4. CNA A stated they looked in all the rooms and closets and could not find him. CNA C notified RN who then called the Code Orange and protocol started. CNA A stated that no one had told her they were working on the gates, otherwise, I would not have let him go outside. CNA A stated that when she was being trained and she was working on her hours, that staff would just let Resident #4 go out and smoke, stating that he will be ok, the gate is locked. CNA A stated that Resident #4 will never be outside alone again. CNA A revealed that she had been in-serviced on the Orange Code, Elopement Protocol, and Supervised Smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 3:21 PM, CNA B stated that she was told to go cover Unit D while CNA C went on her lunch break. CNA B stated that when she got back to the unit, she asked CNA A what she needed to do, and CNA A reported that she had just completed her rounds. CNA B stated that at that point she sat down in a chair just outside the common area. CNA B stated that Resident #4 was wanting a light. CNA B stated that HA came on the unit and was talking to CNA A, and then the RN came in the unit and CNA B stated she was talking to her. CNA B stated that she did not see Resident #4, CNA A, and HA go outside. CNA B stated that while she was talking to the RN, that the other two girls came in and they were all four talking. CNA B stated that when HA was leaving, that HA hollered for CNA A to come assist with a resident, and that HA also notified RN about a resident that she thought might be sick. CNA B stated she was walking off the unit because she saw that CNA C was back on the unit. CNA B stated she went to the nursing station to work on some documentation, and she had four residents to document on. CNA B stated that when the Code Orange was called she had one more resident to chart on. CNA B stated that she cleared her halls she was assigned to, then went outside. Stated she saw CNA A and CNA C outside by a fence, stating that CNA A looked really upset. Stated that the ADON came out and told them someone needed to go back to the unit. CNA C stated she did not want to leave CNA A alone. CNA B stated that she would stay with her, and then CNA A took off running. CNA B stated that she was following her, then she fell and did not CNA A any longer. CNA C stated at that point she went back into the facility, and when she got to the nursing station she heard that they had located Resident #4. CNA B stated that she has been in-serviced on elopement and resident supervision of residents while smoking. During observation on 12/11/2024 at 5:00 PM, Investigator left facility and drove the route that HR had reported she had taken to locate Resident #4. Observed a large vacant field behind the facility. The area contains a residential area, including an apartment complex, with a couple of places of business. Area was remote with no traffic during drive through. During an interview on 12/12/24 at 9:10 AM, ADM stated that Resident #4's care plan stated supervision, which meant that the resident was just to be visually seen, and they were observing from the windows. ADM stated staff have been in-serviced and all residents that smoke have to be directly supervised, meaning the staff have to be outside with the residents. If it is found out that a resident is not being directly supervised, it is automatic termination. ADM stated they have been making observations to make sure staff is complying. ADM stated that she guessed if she would have had someone at the doors and gates while the repair company was here, that this probably would not have happened. ADM stated that CNA C clocked back in on 12/05/2024 at 3:00 PM, and that HA had clocked out at 3:03 PM on 12/05/2024. ADM stated their policy for notifying the police is 30 minutes. ADM stated she was in the process of getting information on what Resident #4 was wearing so she could call them, but Resident #4 had been located prior to her making that call. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/12/2024 at 9:35 AM, the DON came into the Conference Room and had CNA C on the phone. Phone interview with CNA C revealed that on 12/05/2024, she had returned from her lunch break around 3:00 PM. CNA C stated she entered Unit D and she saw RN, CNA A, CNA B, and HA on the other end of the hall. CNA C stated that she had gotten about halfway down the hall when HA hollered for CNA A that a resident was walking without assistance. CNA C stated that CNA A came down the hall to assist with that resident, then another resident was hollering out and CNA A went to check on him. CNA C stated that the RN had instructed them to get some clothes ready for a resident they were sending out. CNA C stated as she and CNA A were getting clothes packed, that is when CNA A stated that Resident #4 was outside smoking, so CNA A went to go check on him. CNA C stated that she heard CNA A yelling he was not out there, stating CNA A was hysterical. CNA C stated she was trying to calm her down and voiced for them to check the closets in all the rooms, because Resident #4 likes to hide sometimes. CNA C stated that they could not locate Resident #4, so she notified RN. CNA C stated that CNA A was being pulled in all directions, and she was just trying to do the right thing. CNA C reported that when she was being trained on the unit, that the staff would let Resident #4 go out to smoke and was told to just keep an eye on him. CNA C stated that now all residents are direct supervision for smoking, and if staff fails to do that, it is automatic termination. CNA C voiced that Resident #4 paces often and he will shadowbox, stating he will swing at you. During an interview on 12/12/2024 at 2:40 PM, the DON stated that they were monitoring smoking times to make sure staff is directly supervising. If staff is found not to be directly supervising, that employee will be immediately terminated. DON reported that the ADM had sent surveys to all of the employees earlier regarding elopement protocol and supervision, stating they all answered correctly. During a phone interview on 12/12/2024 at 2:45 PM, HA stated that on 12/5/2024 that she was getting ready to leave the facility for the day. HA stated that CNA A and her are good friends, so she went back to Hall D secure unit to let her know that she was leaving. HA stated when she got to the unit that CNA A asked her if she had a lighter. HA stated she did not, so she went out of the unit to find a lighter. When she got back, CNA A asked her if she wanted to go out and hit her vape before she left. HA stated that she, CNA A, and Resident #4 stepped outside. CNA A lit Resident #4's cigarette and then he walked to where the turtles are. HA stated after a few minutes she told CNA A that she needed to go, so she stepped inside, and CNA A was asking Resident #4 if he was ready to go in, and he was not ready. HA stated her and CNA A went in, and she saw RN and CNA B sitting in chairs just outside the common area. HA stated when she was leaving she saw a resident who was walking without assistance and yelled for CNA A to come help. HA stated that she saw another resident that she thought might be sick, so she told the RN who went in to check on him. HA stated when they got the other resident settled back in bed, she left the unit. HA stated she was suspended, has been in-serviced on elopement, and direct supervision of residents when they are outside smoking. Observation on 12/12/2024 at 4:35 PM, Resident #4 ambulated out of his room. Investigator introduced self and asked how he was doing. Resident #4 made eye contact but did not engage in conversation. His stance appeared as if he was ready to bolt. Staff walked up and talked with Resident #4. Resident #4 pointed to medication cart and stated he wanted some water. Resident #4 with steady gait followed staff to get water. Observation on 12/11/24 at 8:45 AM front entrance door was locked. Investigator rang doorbell and staff member approached door to enter code. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/11/2024 at 9:50 AM, MDS Nurse revealed that she had been in-serviced on Code Orange drills, Elopement Protocol, and Supervised Smoking. MDS Nurse stated that she helped with the door watches. During an observation on 12/11/2024 at 11:47 AM, Investigator put in the code to Secure Hall D. The alarm sounded upon entering unit and stopped when the door was closed. The alarm goes off when entering and exiting the unit. Resident #4 was resting in bed with eyes closed. The door that goes out to the smoking area also requires a code, and it was working. During an observation on 12/11/2024 at 11:55 AM, Investigator put in the code to Secure Hall C. The alarm sounded upon entering unit and stopped when the door was closed. The alarm goes off when entering and exiting the unit. The same thing occurred when leaving the Secure Hall C unit. The door was working. Record review on 12/11/2024 reviewed the Plan of Correction: Interventions put into place to prevent reoccurrence dated 12/05/2024, the document Self-Reporting Protocol/ Ad Hoc QAPI- Missing Resident or Elopement, Elopement Prevention QA Check List dated 12/05/2024 at 4:30 PM, 6:30 PM, 9:30 PM. 12/06/24 at 1:00 PM and 5:45 PM. 12/7/2024 at 1:00 AM, 3:30 PM, 7:30 PM. 12/08/2024 2:30 PM. Record review of in-service: Smoking Policy: If resident is unsupervised while smoking it will be an automatic termination, dated 12/05/2024 with 57 staff member signatures. Record review of in-service: Elopement Response: Codes are on the back of name badge. If it is not, notify HR for a new name tag. Code Orange is called if an employee discover a resident is missing from the facility. Undated with 59 staff member signatures. The following policy reviewed: Smoking Policy, Resident Admission Packet, revised 11/01/2017. Smoking policies must be formulated and adopted by the facility. The policies must comply with all applicable codes, regulations, and standards, including local ordinances. The facility is responsible for enforcement of smoking policies which must include at least the following provisions: 2. A safe smoking assessment will be done regularly for each resident who smokes. Smoking by resident classified as unsafe will be prohibited except when the resident will be directly supervised by facility personnel or visitors who are aware of the resident's limitations with smoking. 3. If the facility identifies the resident needs assistance/supervision and/or additional protective devices for smoking, the facility includes this information in the resident's care plan, and reviews and revises the plan periodically as needed. The following policy reviewed: Elopement prevention dated 2003, revised 10/27/2010. Policy Statement: Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. 1. Physical Plant: All facility exits that residents have access to will have a device in place to alert staff of possible elopement attempts. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whisperwood Nursing & Rehabilitation Center	5502 W 4th St Lubbock, TX 79416

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	The following policy reviewed: Elopement Response dated 2003, revised 10/27/2010. Policy statement: Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented. Policy Interpretation and Implementation: 2. C. A resident must demonstrate a free willful intent to leave the facility without prior notification of staff or is a wandering, confused resident who leaves the facility unattended. 7. Post return resident evaluation and care: C. The facility will evaluate its elopement prevention program and all residents will be reassessed for elopement. The ADM was notified on 12/12/2024 at 11:45 AM, that a past non-compliance IJ situation had been identified to the above failures. It was determined these failures placed Resident #4, in an IJ situation on 12/05/2024. These failures have the potential to affect all residents residing in the Secure Unit. The facility implemented the following interventions to prevent reoccurrence: Medical Director was notified of the elopement on 12/05/2024 at 4:30 PM. All exit doors and gates were checked by the Administrator on 12/05/2024 at 4:45 PM for proper alarming and functioning. No issues were identified. Repair company was in the facility on 12/05/2024 to assess power voltage. Repair company returned to the facility on [DATE] to continue assessment and repairs around 8:00 AM and repairs were completed around 12:30 PM. On 12/05/2024 staff were posted at the exit doors and gates until repair company completed all repairs. Elopement risk assessments were completed on all residents. Staff were in-serviced on 12/05/2024 on elopement response protocol and smoking policy by DON/Designee. All staff not present will be in-serviced prior to their next scheduled shift by DON/Designee. On 12/05/2024 an AD Hoc QAPI meeting was held with the medical director, facility Administrator, Director of Nurses, and Social Services Director to review the plan of correction. Monitoring: On 12/06/2024 the facility will monitor exit and gates for functioning 5x per week for 4 weeks, and prn thereafter to identify any potential future failures. On 12/06/2024 the DON/Designee will monitor resident smoke breaks for staff supervision 5x a week for 4 weeks and, then prn thereafter. On 12/06/2024 the DON/Designee will monitor elopement risk assessments to ensure completion 5x per week for 4 weeks, then prn thereafter. Interviews, observations, and record reviews confirmed that staff have been in-serviced on direct supervision of residents who smoke and elopement protocol.