

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Harlingen Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3810 Hale St Harlingen, TX 78550	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278</p> <p>Based on interview and record review, the facility failed to ensure adequate supervision was provided for 1 of 3 residents reviewed for accidents and supervision. (Resident #1)</p> <p>The facility failed to ensure Resident#1 received adequate supervision to prevent elopement. Resident #1 eloped from the facility on and was found by the police department approximately 2 miles away from the facility.</p> <p>The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 10/08/2023 and ended on 10/08/2023. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place residents at risk of sustaining serious injury, harm and death.</p> <p>Findings included:</p> <p>Record review of Resident #1's electronic facility face sheet dated 09/19/2024, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Diagnosis of Dementia, Type 2 Diabetes, Depression, and Cerebrovascular Disease (a group of conditions that affect blood flow in the brain).</p> <p>Record review of a Brief Interview for Mental Status dated 10/13/2023 indicated Resident #1 had severely impaired cognition with a score of 03 out of 15.</p> <p>Record review of Resident #1's quarterly MDS dated ,d+[DATE]/2024, revealed his mobility functional abilities for self-care are independent. Resident #1wandering behavior occurred 1 to 3 days ago.</p> <p>Record review of Resident #1's care plan revealed she was an elopement risk/wander, date initiated 10/07/23. Resident #1 eloped facility on 10/8/2023. Interventions included Complete wandering evaluation tool and identify pattern of wandering.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 675606	If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Harlingen Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3810 Hale St Harlingen, TX 78550	
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>Record review of the Incident Report dated 10/08/2023 at 10:05p.m. revealed at 10:05p.m noted resident missing from room. Staff alerted and in facility and surroundings search initiated. At approximately 10:15p.m. police department called and stated Resident #1 had been picked up close to a supply store at 9:42 p.m. No injuries noted to resident but resident noted with confusion. Police department able to contact family via resident cell phone. As per police officer, resident voiced wanting to go home. Immediate Action Taken: MD and RP notified. Full body assessment completed. Vital isgns taken and within normal limits, labs obtained, and one to one initiated.</p> <p>Record review of the Wandering Evaluation dated 10/07/2023, revealed a Score 07 Moderate Risk.</p> <p>Record review of doctors visit records with a History and Physical dated 10/05/23, revealed resident had previously walked out of hospital during a previous visit and had been threatening to leave her home two days before.</p> <p>Record review of progress note dated 10/09/2023, revealed at 10:00 pm noted Resident #1 missing from room. Resident #1 was last seen in room at 9:31pm. Staff alerted, both inside the facility and surroundings search initiated. At approximately 10:15pm law enforcement stated resident had been picked up close to a supply store. No injuries noted to resident, but resident noted with confusion. Police department able to contact family via resident cell phone. As per police department resident in route to facility. At 10:25 pm law enforcement entered building with resident. As per Police officer, resident voiced wanting to go home. MD and RP notified. Full body assessment completed, Vital signs taken and within normal limits, labs obtained. One to One initiated.</p> <p>During an interview on 09/19/2024 at 09:45 a.m., LVN A stated Resident #1 was last seen at approximately 09:31 p.m. when roommates, blood sugar was checked. She stated that as soon as she noticed Resident #1 was not in her room around 10pm and did not know her whereabouts. She came out of the room letting all staff know to start looking. Then other staff started the missing person protocol. LVN A stated she knows that when a resident goes missing to call a code pink right away. She stated the police called at approximately 10:15 a.m. and stated that Resident #1 had been picked up close to the supply store.</p> <p>During an interview on 9/19/2024 at 4:15 p.m. the DON stated, she was not the DON at the time. She stated that Resident #1 was admitted Saturday 10/7/2023 and on Sunday 10/08/2023 at night was when she eloped. She stated she was a moderate risk on the wandering evaluation form on the admission assessment. She stated that the family didn't voice any wandering concerns. Law enforcement used Resident #1's phone, called her family, and then they called the facility. She stated a head count was done. She stated that maybe somebody went out the front door and she walked right behind them. They decided to reeducate everyone on elopement, on accuracy of elopement assessments. She stated they assessed high risk wandering residents for elopement and no scores were modified. Resident #1 was on one-on-one monitoring then she was transferred to a memory care unit for increased supervision. No additional elopement events have been identified since.</p> <p>During an interview on 09/20/2024 at 11:03a.m. the Administrator stated that he ensured that the staff was following the elopement protocol by conducting periodically monthly elopement education and drills. He stated that the drills are unannounced. He stated that the front door code was changed monthly and as needed. Sometimes if they noticed the family member knows the code then they change it right away.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675606	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/20/2024
NAME OF PROVIDER OR SUPPLIER Harlingen Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3810 Hale St Harlingen, TX 78550	
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>Record review of a policy with date implemented of 11/21/2022 titled Elopement and Wandering Residents revealed Policy: The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Definitions: Elopement occurs when a resident leaves the premises or a safe area without the authorization (i. e. an order for discharge or leave of absence), and/or any necessary supervision to do so. Policy Explanation and Compliance Guidelines: 3. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering including identification and assessment of risk evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary.</p> <p>The Administrator was notified on 09/20/2024 at 10:55 a.m., that a past non compliance Immediate Jeopardy situation had been identified due to the above failures.</p> <p>It was determined these failures placed Resident #1 in an Immediate Jeopardy situation on 09/22/2024.</p> <p>The facility had corrected the noncompliance before survey began.</p> <p>The facility had implemented the following interventios.</p> <p>Record review of an In-Service Attendance Record with subject of Elopement Drill and Procedure, dated 10/10/2023, indicated that staff signed the in-service record.</p> <p>During an interview on 9/19/2024 at 4:15 p.m. the DON stated, Resident #1 was placed on a one-to-one monitoring. Resident #1 was transferred to a memory care unit for increase supervision. Assessments of high-risk residents were conducted, and no scores were modified.</p> <p>During interviews on 09/18/2024 at 09:35 a.m. - 09/19/2024 at 11:02 a.m., 3 CNAs were able to identify resident at risk for elopement, she was knowledgeable of the elopement policy and procedure. They were aware of the new expectations to not allow family members to have front door code and to notify the nurse immediately of any resident trying to go outside.</p> <p>During interviews on 09/18/2024 from 10:14 a.m. - 09/19/2024 09:45 a.m., 3 LVNs were able to identify residents at risk for elopement, all were knowledgeable of the elopement policy and procedure, all were aware of the new expectations to not allow any resident outside alone, and to notify the DON/ADON and the Administrator immediately of any resident trying to go outside alone.</p>		