STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675625	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Nursing and Rehabilitation Center	4300 Vista Rd Pasadena, TX 77504

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	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** 47722 49710 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible, and each resident received adequate supervision to prevent accidents for 1 of 18 residents (Resident #91) reviewed for accidents and supervision, in that: The facility failed to supervise Resident #91 on the secure unit, after he attempted to elope 20 minutes prior to eloping, out of the window on 12/31/23. An Immediate Jeopardy (IJ) was identified as past non-compliance on 11/21/24. The non-compliance began on 12/31/23 and ended on 1/2/24. The facility had corrected the non-compliance before the survey began on 11/19/24. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings included: Record review of Resident #91's undated face sheet revealed he was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. Record review of Resident #91's care plan revealed he was on a secure unit, was an elopement risk/wanderer and was at risk for possible injury related to his wandering and diagnosis of Alzheimer's Disease. The care plan also revealed Resident #91 eloped on 12/31/23 through his window in his room on the sercure unit. Record review of Resident #91's Admission Wandering Assessment performed on 12/1/23 by LVN E at 8:04 p.m., revealed a score of 8 which indicating the resident was a high risk for wandering. Record review of Resident #91's Physician Orders by MD C, revealed an order for Memantine HCl Oral Tablet 5 mg, 1 tablet by mouth a day, for memory r/t Dementia. Ordered on 12/1/23. Record review of Resident #91's December 2023 MAR-TAR revealed, RN A documented the resident was having wandering behaviors on 12/31/23 during the day. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675625	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Nursing and Rehabilitation Center	4300 Vista Rd Pasadena, TX 77504

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	Record review of the facility's provider report on 11/21/2024 revealed, the charge nurse was notified that the resident was found on 12/31/23 at 3:05 pm. The report said a complete search of the facility was performed for the resident and it appeared he left via the window. The report said three teams went to search for the resident via cars. It also said the alarm system was tested and was working properly. The report revealed the resident had set off the alarm about 20 minutes prior but did not elope. Per the report, maintenance staff tested the alarm system, and it was working properly. The alarm company also did a test of the system, and everything was working properly. The provider report also revealed the facility staffed dedicated a person to monitor the alarm and the resident for 72 hours after the elopement. Record review of Resident #91's nurses note dated on 12/31/23 at 3:00 pm from RN A stated, Resident set off the alarm, and he was redirected back to his room and staff reset the alarm. About 20 minutes later writer left the Hall to go pick up diagnostic results off the fax for another resident when writer came back to the Hall, one of the CNA's was standing in front of the last room on the right side of the hall, and she said one of the residents in that room is pointing at the window and it's open. Writer did head count and noticed that resident was missing. The note went on to say, RN A last saw the resident at about 2:45 pm, but CNA B was the last person to see him and that was in the dining room. The note said, [at 4:00pm] the police told [RN A] that he has been found that someone dropped him off at the Fire station on [street]. The note said the resident was back at the facility at 4:15 pm and Q15 minute checks were started. Record review of Resident #91's Wandering Assessment performed on 12/31/24 at 4:15 pm by RN A revealed a score of 7 which was a moderate risk for wandering. Record review of Resident #91's nurse's note from 12/31/23 at 6:31 pm by LVN D said, Resident sitting on the hallway in company of a CNA, resident pleasant and talking with staff, Q15 minutes round sheet on progress per facility protocol. CR Record review of Resident #91's history and physical performed by MD C on 1/2/24 revealed, Patient left facility, found at Vista and [NAME] Road. Found by [good Samaritan]. Fire Department brought him back. No new orders. In observation on 11/19/24 at 10:31am resident #91 is observed playing ball in the dining room with other residents with staff supervision. On 11/20/24 at 9:25am observed the alarm monitor screen which indicated it was on. Reviewed alarm company records. In an observation and interview on 11/20/24 at 9:30am resident stated he's doing good. He just took a shower. He states his hair is still wet and requests a towel. Did not observe resident wandering, messing with the windows, or trying to exit. During observations he in the dining room with other residents under staff supervision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675625	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Nursing and Rehabilitation Center	4300 Vista Rd Pasadena, TX 77504

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	In an interview with CNA B on 11/21/24 at 11:01 am, she said she was on her 1 hour break when the elopement happened. She said she left for break after they had given snacks to the residents and then came back around 3 pm. She said when she came back, the resident was gone, and they went outside looking for the resident, but could not find him. She said the police found him at a fire station and a citizen had picked him up and dropped him off there. She said the resident came back close to dinner time and the only complaint was that he wanted water. CNA B said herself, an agency CNA, and one nurse were working on the Secure Unit that day. She said her schedule was Saturday-Sunday from 6am-10pm. She said the windows did not have locks but had alarms that would go off and were loud enough to be heard all through the Secure Unit and outside of the unit by the door. She said to reset the alarm all the windows had to be closed and the alarm panel was at the nurse's station. The CNA stated they were trained on elopement and to notify the nurse as soon as a resident is missing. They search the whole building and perform head counts. In an interview with the Administrator on 11/21/24 at 1:04 pm, he said, he was at the facility for the incident with Resident #91. He said there was no exact answer on how the resident got out. He said the facility partnered with the VA and sent them all the information he had, and they were not concerned . He said the incident happened on a weekend, on a Sunday, and the alarm went off earlier in the day. He said RN A reset the alarm and he thought Resident #91 must have disarmed the alarm because it was working earlier in the day, and no one heard an alarm go off. He said the alarm system worked very well and he had the alarm company come out and check it and it was fine. He said some one found Resident #91 on and took him to the fire station. The Administrator said the Police Department brought Resident #91 back to the facility. He said they performed a Missing Resident in service on how to search for the resident and an in-service on Abuse and Neglect. The Administrator also said Resident #91 was placed on Q15min checks for multiple days. In an interview with RN A on 11/21/24 at 4:12 pm, she said, earlier in the day, the alarm went off in the Secure Unit, but she was not sure why. She said another nurse re-set the alarm. She said she left the Secure Unit to grab an order off the fax and left an agency CNA on the Secure Unit to watch the residents while she left. She said when she got back, the CNA and another resident were pointing into a resident's room. RN A said she went to the room and the window was open and it was Resident #91's room. She said she immediately performed a head count and realized Resident #91 was missing. She said she had performed a head count right before she left the unit to get the lab order off the fax and seen Resident #91 in the dining room. She said CNA B had just left for break and she had seen him before she left. RN A said the facility had not had any other issues with the alarms before that day. She said the alarm that went off earlier in the day could have been from Resident #91's window but she could not remember. Record review reveals resident has not eloped since 12/31/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675625	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Nursing and Rehabilitation Center	4300 Vista Rd Pasadena, TX 77504

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	Record review of facility's policy and procedure on Elopement (no revision date) read in part: Nursing personnel must report and investigate all reports of missing residents. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. Determination of missing resident either by routine nursing rounds or door alarms: Note: A resident is determined missing when he/she leaves the facility without the staff knowledge .Should an employee observe a resident leaving the premises, he/she should: attempt to prevent the departure: obtain assistance from other staff members in the immediate vicinity, if necessary .Should an employee discover the resident is missing from the facility, he/she should: Report to the charge nurse, determine if the resident is out on an authorized leave or pass. If not; make a thorough search of the building(s) and premises .Provide search teams with resident identification information, Make an extensive search of the surrounding area . It was determined this failure placed Resident #91 in an IJ situation from 12/31/24 to 1/2/24. The Administrator was notified and provided with the IJ template on 11/21/24 at 5:34 p.m. The facility took the following action to correct the non-compliance on 1/2/24:. o The facility had Maintenance check the alarm system several times to ensure it was working properly. o The alarm company came out the next day on 1/2/24 at 9 a.m. - 11 a.m. and checked the whole alarm system and ensured it was working. o The alarm company replaced the sensor on Resident #91's window as a precaution. o An employee was placed on the unit who was dedicated to monitoring the alarm and the residents for 72 hrs from 12/31/23 to 1/3/24. o Maintenance tested the alarm system, daily, for 7 days after the incident . o In services on facility elopement, resetting the alarm system, and abuse/neglect were given on 1/2/24 and ongoing. o Rounds were done every 15-minute checks on Resident #91 on 12/31/23, 1/1/24, 1/2/24, 1/3/24. o The incident was brought to QAPI . unknown date. No other issues with elopement since 12/31/23. In an interview with RN A on 11/21/24 at 4:12 pm interviewee stated they had in services on elopement, which included performing a head count and searching the whole building for the resident. Then contacting the police as soon as possible. In an interview on 11/21/24 at 5:17 p.m. CNA B said they were trained on elopement and to notify the nurse as soon as a resident is missing. They search the whole building and perform head counts.