

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675638	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Twin Pines Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3301 E. Mockingbird Lane Victoria, TX 77904	

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** 27923</p> <p>Based on observation, 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 3 residents (Resident #1) reviewed for accidents and supervision, in that:</p> <p>The facility failed to supervise Resident #1 who eloped from the facility on 06/21/24.</p> <p>The noncompliance was identified as PNC. The IJ began on 06/21/24 and ended on 06/22/24. The facility had corrected the non-compliance before the survey began.</p> <p>This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death.</p> <p>The findings included:</p> <p>Record review of the face sheet for Resident #1, dated 11/15/24, revealed the [AGE] year-old male resident was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (a condition of cognitive impairment that can have occur for various reasons), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blow flow to the extremities), and bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>Record review of Resident #1's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of a 8 which indicated that the Resident was cognitively impaired. The MDS indicated that the resident exhibited a moderate risk of wandering behavior.</p> <p>Record review of the Quarterly care plan for Resident #1, initiated on 8/8/22, revealed the resident had a risk of wandering behavior. The interventions included identifying the pattern of wandering, observation, and provided structured activities. Further review revealed the resident's care plan was changed on 6/21/24 to include the resident's elopement on 6/21/24.</p> <p>Record review of wandering assessment for Resident #1, dated 4/17/24, noted the resident had a history of wandering aimlessly and was at low risk for elopement. The wandering assessment was revised on 6/21/24 to include the elopement incident.</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
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<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 physician order summary for Resident #1, dated 6/20/24, revealed the resident was under the care of the medical director for medication management and behavior monitoring.</p> <p>Record review of the one-on-one supervision log for Resident #1, dated 6/21/24, revealed the resident was under continuous one-on-one supervision by nursing staff upon return to the facility from the elopement including supervision during the resident's transfer to the hospital on 6/21/24.</p> <p>Record review of the facility's incident report dated 6/21/24 revealed that the facility's van driver began looking for the Resident #1 at 8:15 a.m. on 6/21/24. Code Orange for elopement protocol was called at the facility on 6/21/24 at 8:30 a.m. Family and physician notifications were initiated. All of the facility's rooms were searched with all other residents' whereabouts being noted. The facility staff conducted a search of the facility grounds and surrounding locale. Resident #1 was located several blocks for the facility at 8:50 a.m. at a convenience store. Local law enforcement was also at this location at the time. Resident #1 was brought back to the facility and a full head to toe assessment was conducted by nursing staff with no injuries noted. Resident #1's physician ordered that Resident #1 be transported to the hospital on 6/21/24 at 9:15 a.m. for further evaluation. The summary of the incident report finding was that the Resident went out of one of the facility entrance doors but the elopement was unwitnessed.</p> <p>Record review of world weather.info website revealed the morning temperature on 6/21/24 in [NAME], TX was 77 degrees Fahrenheit.</p> <p>Review of Google Maps revealed that on 6/21/24 Resident #1 would have crossed one street, E Mockingbird Lane to arrive at the convenience store located at 2602 E Mockingbird Lane, [NAME], TX.</p> <p>Observation from 11/13/24 to 11/15/24 between the hours of 8:00 a.m. and 4:00 p.m., of all the resident corridor hallways revealed the door alarms were in working order.</p> <p>Observation on 11/15/24 at 9:45 a.m. with the Administrator revealed that all of the facility's exit doors were tested for door alarm efficacy with no concerns noted.</p> <p>During an interview with the Administrator on 11/14/24 at 9:55 a.m. regarding the elopement incident, the Administrator stated that Resident #1 had eloped from the facility on 6/21/24 sometime around 8:00 a.m. The Administrator stated that the facility's van driver began looking for the Resident #1 at 8:15 a.m. on 6/21/24. Code Orange for elopement protocol was called at the facility on 6/21/24 at 8:30 a.m. Family and physician notifications were initiated. All of the facility's rooms were searched with all other residents' whereabouts being noted. The facility staff conducted a search of the facility grounds and surrounding locale. Resident #1 was located several blocks for the facility at 8:50 a.m. at a convenience store. Local law enforcement was also at this location at the time. Resident #1 was brought back to the facility and a full head to toe assessment was conducted by nursing staff with no injuries noted. Resident #1's physician ordered that Resident #1 be transported to the hospital on 6/21/24 at 9:15 a.m. for further evaluation. The Administrator stated that she had ordered on 6/21/24 that all facility's exit doors be checked for door alarm and closure viability. The Administrator advised that all of the facility's resident assessments for elopement were updated on 6/21/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with the Assistant Maintenance Director on 11/15/24 at 10:45 a.m., the Assistant Maintenance Director stated that regular inspections of all of the facility's exit doors for alarm and door closure effectiveness are done three times a week.</p> <p>Record review of the undated facility's policy titled, Elopement Prevention and Elopement Response revealed, Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement.</p> <p>The Administrator was notified on 11/15/24 at 3:00 p.m., that a past non-compliance IJ situation had been identified due to the above failure.</p> <p>It was determined the failures placed Resident #1 in an IJ situation on 6/21/24.</p> <p>The facility implemented the following interventions.</p> <p>The Quarterly care plan for Resident #1 initiated on 5/15/24 revealed was changed on 6/21/24 to include the resident's elopement on 6/21/24.</p> <p>Record review of wandering assessment for Resident #1 was revised on 6/21/24 to include the elopement incident.</p> <p>All of the residents in the facility on 6/21/24 had their elopement risk assessments reviewed and updated.</p> <p>During an interview on 11/14/24 from 11:10 a.m. to 11:55 a.m. with Charge Nurse A, Guest Relations Staff B, Occupational Therapist Staff C, ADON D, Housekeeping Supervisor E, and Van Driver F, they stated that they had participated in the elopement exercise to find Resident #1 on 6/21/24. These staff were all present in the building at the time of the elopement by Resident #1. They stated they had been re-serviced on the elopement protocol on 6/21/24 and were aware of what to do to monitor and intervene with residents who have exit-seeking behaviors.</p> <p>During an interview with the Human Resources Director (HR Q) on 11/14/24 at 12:30 a.m., she confirmed stated that all of the facility's active staff had been in-serviced on the elopement protocol on 6/21/24.</p> <p>During an interviews on 11/14/24 from 1:00 p.m. to 2:00 p.m. the following staff (Activity Director, CNA G, CNA H, CNA I, COTA J, LVN K, RN L, [NAME] M, DA N, DA O, DA P, HR R, Housekeeper S, Housekeeper T, MA U, MA V, PTA W, PTA X, Rehab Director Y, RA Z stated they had been in-serviced on elopement protocol call Code Orange, what to do when a resident was missing by calling Code Orange, telling staff, and searching for the resident, and what to do when a resident was trying to elope-try and re-direct the resident, tell the nurse, and stay with the resident.</p>		

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<p>F 0806</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47611</p> <p>Based on observation, interview, and record review, the facility failed to ensure that food that accommodates resident allergies, intolerances, and preferences for 1 of 8 residents (Resident #13) reviewed for resident allergies, intolerances, and preferences, in that:</p> <p>On 09/04/2024 Resident #13 was given meatloaf with egg causing an allergic reaction. Requiring Resident #13 to use emergency medication and be transferred to the hospital for further evaluation.</p> <p>The noncompliance was identified as PNC. The IJ began on 09/04/24 and ended on 09/05/24. The facility had corrected the non-compliance before the survey began.</p> <p>These failures could place residents at risk of harm, serious injury, or death.</p> <p>Findings were:</p> <p>Record review of Resident #13's face sheet dated 11/13/2024, revealed an original admitted [DATE] and a re-admitted [DATE] with diagnoses of: personal history of anaphylaxis (a severe, life-threatening allergic reaction), chronic obstructive pulmonary disease (lung disease making it hard to breathe), angina pectoris (chest pain/discomfort).</p> <p>Record review of Resident #13's MDS, dated [DATE], showed a BIMS score of 13 indicating intact cognition.</p> <p>Record review of Resident #13's Care Plan, dated 10/23/2024, showed, Allergic to Influenza Vaccine Live, Chicken Derived Substance, Levaquin and Eggs.</p> <p>Record review of Resident #13's electronic health record revealed on 09/24/2024 Resident #13 was given meatloaf for lunch which contained egg as a binding agent.</p> <p>Record review of nursing note dated 9/4/2024 revealed Resident #13 alerted nursing staff via call light that he was having symptoms of allergic reaction after consuming meatloaf and self-administered epi-pen at bedside.</p> <p>Record review of nursing note dated 9/4/2024 revealed Resident #13 alerted nursing staff via call light that he was having symptoms of allergic reaction after consuming meatloaf and self-administered epi-pen at bedside.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>- 9/4/2024 at 16:02 [4:02 p.m.], Resident Trferred to [hospital name] ER By EMS, NP notified at 13:32 [1:32 p.m.], DX: Allergic Reaction, Epi-pen administered at 13:12 [1:12 p.m.], Resident is his own RP and Family [family member name] notified, DON in room and aware, O2 at 15L per non-rebreather mask administered. Tongue was swollen at time of epi-pen given and hd subsided by the time EMS arived at 13:35 [1:35 p.m.]. V/S B/P-150/90, P-84, R-14, T-97.1 O2 Sat 100% via non-rebreather mask at 15L. Resident has allergy to eggs and chicken derived substances. Meatloaf tray present in Room, but tray looked untouched. Report called into to ER Nurse at [hospital name] hospital at 13:46 [1:46 p.m.]. called [hospital name] ER for patient status. ER Nurse reported to this nurse at 15:59 [3:59 p.m.] that patient is stable but unsure if he is being admitted or returning to facility.</p> <p>- 9/4/2024 at 21:26 [9:26 p.m.], At 21:19 [9:19 p.m.] resident returned from ER per facility van with no N/O. Resident up walking and V/S 158/107 P-85, R-18, T-97.4, O2 sat 100%. Resident eating noodles from home in room. no c/o Epi-pen in lock box at bed side</p> <p>Record review of Resident #13's hospital record, dated 9/4/2024, revealed: Allergic reaction secondary to eggs.</p> <p>Record review of written statement from cook dated 9/4/2024 showed, I know I made meatloaf for lunch didn't follow the recipe .</p> <p>During an interview on 11/13/2024 at 1:00 p.m. with DFN stated that prior to giving the meatloaf to the resident, she had asked CC if egg was used, and CC denied using egg. She stated after the allergic reaction to the resident and once the resident returned from the hospital, she again asked CC if egg was used. She stated CC admitted to using egg in the meatloaf.</p> <p>During an interview with Resident #13 on 11/13/2024 at 1:30 p.m., the resident stated he did recall the incident in question. He said injected himself with his epi-pen which he keeps in his room in a locked box. He said he found out later that they had used egg in the meatloaf he had consumed during lunch on 9/4/2024. He stated he has had no further issues.</p> <p>An interview was attempted on 11/15/2024 at 12:53 p.m. with the Cook. There was no answer and voice message was left for a return call. At 12:55 p.m. a person returned the call form the cook's phone number and said this was not the cook's number anymore and to stop calling this number.</p> <p>The facility administration staff were notified on 11/15/2024 at 3:00 p.m., that a past non-compliance IJ situation had been identified due to the above failures.</p> <p>It was determined these failures placed Resident #13 in an IJ situation on 9/4/2024.</p> <p>Prior to the investigation on 11/13/2024, the facility had put into place interventions to prevent allergic food reactions.</p> <p>Interventions included:</p> <p>Assessment of Resident #13 was completed on 09/04/24.</p> <p>Inservice training to all dietary staff related to food allergies and food preparation for residents with food allergies was conducted on 08/31/2024 and 09/05/2024, after the incident occurred.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Simplified menus created with resident regarding safe foods and preferences, completed 9/5/2024.</p> <p>All residents with known allergens will have colored meal cards at every meal completed 9/5/2024.</p> <p>All meals will be made separately and in a designated area completed 9/5/2024.</p> <p>All meals will be approved by DFN and RN then taken to resident by authorized staff completed 9/5/2024.</p> <p>Resignation of [NAME] on 9/5/2024.</p> <p>ANE training was completed for all staff, including the dietary staff, on 11/11/2024.</p> <p>During an interview on 11/14/2024 from 12:00 p.m. and 12:30 p.m. with dietary staff [NAME] M, DA N, DA O and DA P, they stated they had participated in the in-service regarding food allergies and food preparation for residents with food allergies.</p> <p>During an interview on 11/14/2024 from 1:00 p.m. to 2:00 p.m. the following staff, CNA G, CNA H, CNA I, RN L, [NAME] M, DA N, DA O, DA P, stated they had been in-serviced on Abuse, Neglect and Exploitation regarding identification, interventions and reporting ANE.</p> <p>During an interview on 11/14/2024 at 4:20 p.m. with LVN AA stated that for residents with food allergies, their food was prepared separately from other residents and that nurses had to go to the kitchen to check the tray before it was given to the resident.</p> <p>During an interview on 11/14/2024 at 4:49 pm with Dietary Supervisor stated that residents with food allergies trays were prepared in separate area. For food preparation the meal ticket listed the resident's allergies and dietary staff keep a copy of the resident lists with food allergies in the kitchen too. Only 1 dietary person prepared the food for residents with food allergies to help prevent cross-contamination of allergens.</p> <p>On 11/15/2024, Records reviewed showed, Dietary staff have been re-educated regarding resident's specific allergy to chicken and eggs. A simplified menu was created with the resident regarding safe foods and his preferences. The DM and/or designee checks residents food trays for potential allergens. The Charge Nurse will also check food trays for potential allergens prior to serving.</p> <p>Observation on 11/15/2024 at 12:00 p.m. revealed dietary staff prepared trays for residents that have a food allergy. There was only 1 staff that prepared the trays for residents with food allergies. The trays were prepared in another area of the kitchen, away from the regular food. Observed that the meal tickets with residents with food allergies were color coded.</p>		