STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675703	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cross Timbers Rehabilitation and Healthcare Center	3315 Cross Timbers Rd Flower Mound, TX 75028

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents. The facility failed to ensure Resident #1 was provided with adequate supervision to prevent him from eloping from the facility on 05/05/25. He was found down the street away from the facility and was brought back by the local police department. The noncompliance was identified as past noncompliance. The Immediate Jeopardy began on 05/05/24 and ended on 05/06/24. The facility had corrected the noncompliance before the investigation began. This failure could place residents who require supervision at risk of harm, severe injury, and possible death. Findings included: Record review of Resident #1's Quarterly MDS Assessment, dated 09/16/25, reflected the resident was a [AGE] year-old male who was admitted to the facility on [DATE]. He had a BIMS (mental status assessment) score of 09 indicating he had moderate cognitive impairment. His active diagnoses included non-traumatic brain dysfunction (causes damage to the brain by internal factors such as lack of oxygen, exposure to toxins, or pressure from a tumor), non-Alzheimer's dementia (the loss of memory and other intellectual functions severe enough to cause problems in one's abilities to perform activities of daily living), and Parkinson's disease (a brain disorder that affects movement and causes tremor, stiffness, and slowness). His MDS indicated he had behaviors of having delusions and had exhibiting wandering behavior for 1 to 3 days. Record review of Resident #1's Wander Data Collection, dated 12/23/24, reflected a score of 14 which was considered high. Record review of Resident #1's Wander Data Collection, dated 04/20/25, reflected a score of 24 which was considered high. Record review of Resident #1's Wander Data Collection, dated 05/06/25, reflected a score of 24 which was considered high.Record review of the facility's Provider Investigation Report, completed by the Former Administrator and dated 05/07/25, reflected on 05/05/25 at 7:00 PM Resident #1 wandered away from the facility, and he did not sustain any injuries. The Investigation Summary reflected the following:RE: [Resident #1].Age 71 Dx: Unspecified Dementia, Insomnia, PTSD, Parkinson's. BIMS 7.This is written follow-up to a previously reported incident for [the Facility] concerning a wandering event for [Resident #1].[Resident #1] walked out the front door of the facility following a couple out. [Resident #1]'s wander guard was operational. During the investigation, [Resident #1] claimed that he waited until someone exited and counted the clicks (the time before the door locks) and walked out after them around 7:00pm. [Resident #1] was seen less than a half mile from the facility at a [local business] and escorted back to the facility after he told the police where he lived which was [the Facility].[Resident #1] has a history of PTSD and gets very anxious when he cannot contact his wife. If this occurs, he paces the floor looking for her. This day, he was determined to go find her. Nurse [LVN A] saw [Resident #1] attempt to use the front door twice which triggered the wander guard alarm. Both times, she redirected him to his room. Around 7:00pm, he went to lunch and returned to pass medications to her residents. At 8:00pm, police returned [Resident #1] to the facility. [LVN A] performed an assessment to which there were no injuries to [Resident #1]. [LVN A] failed to put [Resident #1] on 1:1 at 6:45 or contact facility administration. [LVN A] failed to notify the facility administration upon his return until after because she was passing medication. She notified the DON at 11:19pm by text. Administrator began exhaustive investigation immediately.During staff interviews, staff state they heard the alarm and went to help get [Resident #1] away from the door the first two times but no one seems to recall the alarm at 7:00pm. Investigation shows [Resident #1] was wearing the wander guard and upon immediate inspection, the wander guard system worked properly with [Resident #1]s device.The Administrator immediately initiated the post elopement plan of action. Staff were immediately inserviced on the elopement policy and were not allowed to work their next shift until training and testing was completed. A wander guard check of the 4 individuals in the facility all functioned properly. An audit of wander guard maintenance checks and elopement drills were done and were done and recorded. The QAPI team along with Medical Director was immediately called to ADHOC QAPI meeting to discuss next steps and education. Witness statements from everyone present from 6:00pm to 8:00pm on 5/5/25 were interviewed and witness statements collected.In conclusion, [LVN A]'s failure to notify administration caused a situation that required a 1:1 assignment to be missed. Her failure to protect and monitor resident as the charge nurse ultimately led to her immediate dismissal for putting a client at risk of danger. Upon investigation, it was clear that this charge nurse decision put our system in jeopardy Record review of Resident #1's Psychiatric Evaluation, dated 05/07/25, reflected