STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675812	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45810

Based on interviews, and record review the facility failed to ensure residents were free from abuse for 2 of 6 residents (Resident #5 and Resident #2) reviewed for resident abuse.

1. The facility did not ensure Resident #5 was free from abuse when Resident #6 attempted to choke and struck Resident #5 on the middle of his back on 12/25/24.

2. The facility did not ensure Resident #2 was free from abuse when Resident #3 slapped Resident #2 on his left upper arm on 12/20/24.

The noncompliance was identified as PNC. The noncompliance began on 12/20/24 and ended on 12/26/24. The facility had corrected the noncompliance before the survey began.

These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.

Findings included:

1.Record review of Resident #5's face sheet dated 03/06/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses Schizophrenia (mental health condition that affects everything from how you think to how you feel and behave), mild cognitive impairment, high blood pressure, and depression (common mental health condition characterized by persistent feelings of sadness, loss of interest, and low energy that interferes with daily life).

Record review of Resident #5's annual MDS dated [DATE] indicated he rarely made himself understood and he sometimes understood others. The MDS also indicated he did not have a BIMS score, he had short-term and long-term memory problems, and moderately impaired cognition and no behaviors.

Record review of Resident #5's care plan dated 02/21/25 indicated Resident #5 had cognitive loss/dementia and required staff to monitor for cognition or confusion, remind resident of scheduled activities, and staff to assist in decision making as needed.

Record review of Resident #5's skin assessment dated [DATE] indicated he had no skin issues.

(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: 675812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 S Beech St Winnsboro, TX 75494	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of Resident #6's face sheet dated 03/06/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), anxiety (an intense and excessive and persistent worry and fear about daily situations), high blood pressure, and parkinsonism (disorder of the central nervous system that affects movement and often causes tremors). Record review of Resident #6's EMR indicated he did not have a MDS because he was a respite care (temporary relief stay for caregivers to have a break, usually lasts 5 days) resident. Record review of Resident #6's care plan dated 11/13/24 did not indicate any behaviors. Record review of Resident's #6's baseline care plan dated 12/20/24 did not indicate any behaviors. Record review of Resident #6's safety monitoring dated 12/25/24-12/26/24 indicated monitoring was completed until Resident #6 discharged on ,d+[DATE].24. Record review of the facility PIR dated 12/31/24 indicated on 12/25/24 LVN E observed Resident #6 to have hands on Resident #5's throat in their bathroom and Resident #6 hit Resident #5 in his back. The were immediately separated and Resident #6 was placed on 1 on 1 observation. The facility was noted to have contacted the families of both residents, the Medical Director, and the Veteran's Affairs. LVN E contacted the abuse coordinator, and an abuse and neglect in-service were provided to the secured unit as well as in-service on proper rounding of the unit. The Social Worker conducted safe surveys and resident interviews and head to toe assessments were completed for both residents. During an interview on 03/03/25 at LVN E said close to 10PM on 12/25/24 herself, CNA E, and CNA CC were talking, standing at the nurse station and they heard a loud noise, so they all ran into the Resident #5's room. When they entered the bathroom Resident #6 had Resident #5 by the throat. LVN E said she then separated the residents, and she took Resident #5 to the nurse station and left Resident #6 to be accompanied by CNA C. LVN E said when she turned around, she noticed Resident #6 coming and he hit Resident #5 in his back with a cup. She said CNA CC had walked out with Resident #6 and CNA C went with her to accompany Resident #5. LVN E said when he hit Resident #5, they placed him on 1 on 1 observation, and she notified the Administrator and the DON immediately. LVN E said Abuse and neglect in-servicing were completed by the Administrator. LVN E said Resident #6 had never been aggressive, and he had stayed at the facility for a respite stay a month before that incident. She said Resident #6 was discharged on [DATE]. During an interview on 03/03/25 at 5:14 PM CNA CC said she was not working on the unit on the day that Resident #5 and Resident #6 had the incident. During an interview on 03/06/25 2:25 PM CNA C said she was working on the unit on that evening, and she could not remember what CNA was working with her but her and LVN E and other CNA ran to the room to find Resident #6 with his hands on the throat of Resident #5 and they were separated. She said she went to the Nurse station with Resident #5 and some how Resident #6 got away from the other CNA and came to the nurse station and hit Resident #5 in his back with a cup. CNA C said they placed Resident #6 on 1 on 1 observation with the other CNA. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 S Beech St Winnsboro, TX 75494	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/06/25 at 2:46PM the DON said she remembers that LVN E called her and said they had to separate Resident #5, and Resident #6 related to a resident-to-resident altercation that occurred. The DON said Resident #6 was placed on 1 on 1 observation and skin assessments for both residents were performed. The DON said she did not recall Resident #6 hitting Resident #5 in the back. She said she expected all residents to be separated and kept safe and she expected the aggressor to had immediately be placed on 1 on 1 until the aggressor was cleared by psychological evaluation or sent to the emergency room . The DON said the failure placed other residents at risk for abuse and that all staff were responsible for ensuring residents were not abused and any allegations should be reported to the administrator immediately if suspected. The DON said she expected any resident-on-resident abuse to reported to the administrator immediately. During an interview on 03/06/25 at 3:12 PM The Administrator said she understood LVN E heard commotion and the LVN E and CNAs went to Resident #5's room and found Resident #6 with his hands on Resident #5's throat and the two residents were separated. She said Resident #6 was placed under 1 on 1 care to prevent any other abuse. The Administrator said her expectation was separating the residents to ensure safety, placing the resident who harmed the other on 1 on 1 observation, and ensuring the safety of all residents. She said education to the staff of what to do when a resident-to-resident altercation occurred, what was expected of them, and monitoring of residents was provided on 12/26/24. The Administrator said she expected any resident who had aggressive behaviors to have an evaluation by Psychology after any incident of behaviors of abuse upon another resident. She said the incident was surprise to her and all other staff because Resident #6 had no prior behaviors of that nature. 46928 3. Record review of Resident #2's face sheet dated 03/06/25, indicated an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included dementia (memory loss), mood disorder, hypertension (high blood pressure), cerebrovascular disease (condition that affects blood flow to the brain), and encephalopathy (brain disease that alters brain function or structure). Record review of Resident #2's quarterly assessment dated [DATE], indicated Resident #2 was usually understood and usually understood others. Resident #2 had a BIMS score of 7, which indicated his cognition was severely impaired. Resident #2 did not have any behaviors. Record review of Resident 2's comprehensive care plan dated 02/20/25 indicated Resident #2 resided in the secure unit related to at risk for elopement. The care plan interventions included to keep environment free of possible hazards and to monitor to assure resident safety. Record review of Resident #2's physician order report dated 03/01/25-03/31/25 indicated Resident #2 had an order for may resident on secure unit with an order start date of 01/24/25. Record review of Resident #2's progress note dated 12/20/24 at 4:08 PM, indicated . SW met with resident to discuss incident that happened around 1545 (3:45 PM). Resident was visiting with family in the common area of [secure unit]. Resident was singing, laughing and praising Jesus. SW notified family of incident that occurred with another resident. RP wanted to know who it was, SW stated she could not tell them but that we were addressing situation and would keep resident away from said resident. SW asked resident if someone had been mean to resident. He stated no, that he was just 'praising the Lord and happy to be alive.' SW asked resident if he was upset and he stated no. Resident has no recollection of incident and shows no sign of distress. SW will continue to assist as needed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's weekly skin assessment dated [DATE], did not any skin issues. Record review of Resident #2's safety one on one monitoring dated 12/20/24, indicated Resident #2's monitoring was initiated at 4:00 PM and completed until Resident #2 left to the hospital at 4:45 PM. 4. Record review of Resident #3's face sheet dated 03/06/25, indicated an [AGE] year-old female who readmitted to the facility on [DATE] with diagnoses which included dementia (memory loss) with behaviors, hypertension (high blood pressure), anxiety (intense, excessive, and persistent worry and fear about everyday situations), chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breathe) and osteoarthritis (joint disease that causes pain, stiffness, and swelling in the joints). Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #3 had a BIMS score of 07, which indicated her cognition was severely impaired. Resident #3 did not have any behaviors. Record review of Resident #3's physician order report dated 03/01/25-03/31/25, indicated Resident #3 had an order for may reside on secure unit with an order start date of 07/24/24. Record review of Resident #3's comprehensive care plan dated 12/20/24, indicated Resident #3 had exhibited aggressive behavior toward others with interventions to attempt to find out reason for behavior, notify physician and family as needed regarding any concerns and refer to psychiatric services. Record review of the facility's PIR dated 12/20/24 with an incident category of resident to resident indicated Resident #2 was the alleged victim and Resident #3 was the alleged perpetrator. The report indicated Resident #3 was witnessed to open slap [Resident #2] on upper right arm. [Resident #3] was agitated by [Resident #2] repetitive noise and asked him to stop. The report indicated LVN E was the witness to the incident. The report indicated the provider response was Residents separated immediately. [Resident #3] was placed on 1:1 immediately. Families, medical director, VA notified. Abuse Coordinator notified; abuse in-service conducted. Social services conducted safe survey and resident interviews. Head to toe assessment completed. The PIR indicated investigation findings were confirmed. The PIR reflected staff was in-serviced promptly on abuse, reportable events policy, and examples of abuse on 12/20/24. The PIR included Resident #2's and Resident #3's skin assessments completed on 12/20/24, Resident #3's one on one monitoring completed on 12/20/24 until she was sent to the hospital , Resident #2's and Resident #3's progress notes dated 12/20/24, Resident #3's updated care plan regarding aggressive behaviors, resident safe surveys completed on 12/20/24, and monitoring completed on staff interviews on abuse on neglect. Record review of Resident #3's progress noted dated 12/20/24 at 4:05 PM, indicated . SW met with resident to discuss incident that happened about 15:45 (3:45 PM) Resident was laughing with another female resident. SW asked resident how she was doing and she stated that she was great. SW asked resident if something had happened to upset her and she stated no, she was visiting with her friend. Resident has no recollection of incident and shows no sign of agitation or aggression. SW will assist as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 S Beech St Winnsboro, TX 75494	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's progress note dated 12/20/24 at 4:47 pm and signed by LVN E, indicated . Resident taken to [local hospital] for evaluation. Resident was transported via facility van accompanied by two facility staff members. Record review of Resident #3's weekly skin assessment dated [DATE], did not any skin issues. Record review of the in-service training report dated 12/20/24, indicated staff was in-serviced on abuse/reportable events, immediately notifying the administrator for any abuse allegations, and the types of abuse. Record review of 9 resident safe surveys completed on 12/20/24 with no concerns of abuse. Record review of Resident #3's hospital physician discharge summary dated 12/23/24, indicated . She was admitted on [DATE] with concern regarding agitation combined with dementia . During an interview on 03/04/25 at 3:29 PM, LVN E said on the day of the incident Resident #2 was making his normal noises for him, Resident #3 came up to him and hit him on his arm. LVN E said she immediately separated them and reported it to the Administrator and DON. She said she had been across the room at the nurse's station when she saw the incident happen. LVN E said when a resident-to-resident incident occurred, the residents were immediately separated, the Administrator and DON were notified, one on one behavior monitoring initiated, incident documented, and skin assessments completed. LVN E said Resident #3 was on one on one until she left to the hospital that day. LVN E was able to answer questions regarding abuse and neglect in-service, separating the perpetrator, notifying the abuse coordinator immediately for any abuse allegations and types of abuse. During an interview on 03/06/25 at 2:30 PM, the DON said Resident #2 was making a noise and Resident #3 told him to stop and then slapped him. She said the residents were immediately separated and residents were assessed. She said when a resident to resident occurred, she expected all residents to be separated and kept safe and she expected the aggressor to had immediately be placed on 1 on 1 until the aggressor was cleared by psychological evaluation or sent to the emergency room . The DON said she expected any resident-on-resident abuse to reported to the administrator immediately. During an interview on 03/06/25 at 3:00 PM, the Administrator said Resident #2 had been making repetitive noises, Resident #3 was frustrated and with open hand hit him. She said there were no injuries to either resident. The Administrator said she was the abuse coordinator and when a resident-to-resident altercations occurred she expected staff to make sure both residents were safe, to immediately notify her, assess residents and see if there were any concerns of what prompted the behavior. Record review of the facility policy for Abuse/Reportable Events effective 1-10-2017 indicated: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. The noncompliance was identified as PNC. The noncompliance began on 12/20/24 and ended on 12/26/24. The facility had corrected the noncompliance before the survey began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on interview, and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 6 residents reviewed for misappropriation of resident property. (Resident #4) The failed to ensure CNA/Van Driver K did not take Resident #4's debit/credit card and use it for her personal use. The noncompliance was identified as PNC. The noncompliance began on 08/12/24 and ended on 08/12/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for decreased quality of life, misappropriation of property, misappropriation of physician ordered medications and dignity. Findings included: 1.Record review of Resident #4's face sheet dated 03/06/25 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnosis of dementia (memory loss), depression, and anxiety. Record review of Resident #4's quarterly MDS dated [DATE] indicated he had clear speech, understood others, and was understood by others. The MDS also indicated Resident #4 had a BIMS score of 10 and had moderately cognitive impairment. Record review of Resident #4's care plan dated 04/29/24 indicated he had cognitive loss/dementia and required staff to assist him with decision making as needed throughout the day. Record review of the PIR dated 12/14/24 indicated misappropriation of funds from Resident #4 by CNA/Van Driver K was confirmed. Record review of the police report emailed 03/06/25 and dated 08/08/24 indicated police had photos and camera footage of CNA/[NAME] Driver K getting money from the bank ATM with #4's debit/credit card. Per the police report the transactions were: 07/28/2024 11:49 for $300.00 07/29/2024 10:56 for $150.00 07/30/2024 06:48 for $60.00 Total amount stolen (all days): $510.00 The police report further indicated: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The first initial fraudulent transaction was on 12/29/2023. The most recent documented fraudulent transaction was to be 07/30/2024. It was determined through the investigation and the records provided that there was a total of 59 fraudulent transactions completed without the effective consent of the cardholder or the fiduciary of the account. The investigation was completed and forwarded Criminal Investigation Department for further investigation. During a telephone interview on 03/06/25 at 12:21 PM CNA/Van Driver K said she had an attorney that can talk to the surveyor about what was needed to be known. She said she refused to talk. During an interview on 03/06/25 at 1:35 PM the Social Worker said CNA/Van Driver K had been noticed by her being very attentive to Resident #4's needs on several occasions. She said she [NAME] gone to speak to Resident #4's Fiduciary of his financials and asked for her to look at his records because the aide seemed suspicious. The Social Worker said the allegation was reported to the state on 08/12/24 as well as the police. The police officer had sent a photo that was confirmed to be CNA/Van Driver K that showed she had gone to the ATM on several occasions and had taken money from Resident #4's account. She said CNA/Van Driver had taken Resident #4 to the bank at some point and replaced his card and obtained a new PIN number to have access to the money. The Social Worker said when the facility realized the problem the Fiduciary and Social Worker closed Resident #4's account. She said CNA/Van Driver K was then terminated from the facility. During an interview on 03/06/25 at 2:46 PM The DON said she saw CNA/Van Driver K and Resident #4 behind a closed door on an unrecalled date and the Social Worker investigated Resident #4's financial information starting on 08/12/24 and found several charges on his card at locations the facility staff knew Resident #4 could not have completed. The police were notified on 08/12/24 and CNA/Van Driver K was terminated. The expectation was for no staff to steal from residents. The DON said the facility staff were educated endlessly on abuse neglect and misappropriation. The DON said the failure placed a risk for negative outcomes and loss of money for all residents. During an interview on 03/06/25 at the Administrator said she reported the incident on 08/12/24 and the CNA/Van Driver K was found to have taken Resident #4's card and used it. She said she had completed follow up calls with the local police department and they were working on a federal warrant to get the CNA. The Administrator said she was unsure how CNA/Van Driver K got Resident #4's card but they found the unusual transactions and had access, then the facility called the police and worked together to figure it all out. She said she did not refer CNA/Van Driver K because she thought the state completed referrals. The Administrator said the failure placed a risk of the longevity of the misappropriation for Resident #4 and any other resident. Record review of CNA/Van Driver K's personnel file indicated she was hired on 02/08/23 and had a background check performed on 02/06/23 with no negative results. The personnel also indicted CNA/Van Driver K had an employee disciplinary report dated 08/12/24 with the disciplinary action of termination related to the misappropriation of resident funds confirmed by police officers. Record review of the facility policy for Abuse/Reportable Events effective 1-10-2017 indicated: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. The noncompliance was identified as PNC. The noncompliance began on 08/12/24 and ended on 08/12/24. The facility had corrected the noncompliance before the survey began.

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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** 46928 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and provide supervision to prevent avoidable accidents for 1 of 2 residents (Resident #1) reviewed for quality of care. The facility failed to ensure Resident #1 was adequately supervised which resulted in Resident #1 leaving the facility on 08/12/24, walking approximately 0.5 miles , and crossing a busy 2 lane road. The facility failed to ensure the ADON put measures in place to keep Resident #1 from leaving the facility when she said she saw Resident #1 climb the fence. The facility failed to monitor and put measures in place to keep Resident #1, who was high risk for elopement, from eloping after voicing wanting to go home. The noncompliance was identified as PNC. The IJ began on 08/12/24 and ended on 08/14/24. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of potential accidents, injuries, harm, or death. Findings included: Record review of Resident #1's face sheet dated 03/04/25, indicated a [AGE] year-old male who admitted to the facility on [DATE]. Resident #1 had diagnoses of dementia (memory loss) with behaviors, anxiety (mental health condition characterized by excessive worry, fear, and nervousness), depression (mental health condition characterized by persistent feeling of sadness, loss of interest, and low energy that can significantly interfere with daily life), and hypertension (high blood pressure). Record review of Resident #1's admission MDS assessment dated [DATE], indicated Resident #1 was usually understood and sometimes understood others. Resident #1 had a BIMS score of 4, which indicated his cognition was severely impaired. Resident #1 had delusions and received hospice care. The MDS assessment indicated Resident #1 did not wander. Resident #1 required setup or clean up assistance with eating, oral hygiene, toileting, and personal hygiene. Record review of Resident #1's comprehensive care plan dated 08/12/24 and last revised on 08/14/24 indicated Resident #1 was at risk for elopement as evidenced by repetitive statements of going home. The care plan interventions indicated staff to orient and redirect resident as needed, attempt to find the source of behaviors, divert resident's attention, and refocus attention elsewhere, elopement assessment performed quarterly, with significant change, and as needed, monitor and record behaviors, when it occurred and notify physician and family of any further concerns. Record review of Resident #1's physician order reported dated 08/01/24-08/31/24 indicated Resident #1 had the following orders: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 S Beech St Winnsboro, TX 75494	

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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	o Depakote 125mg give one tablet by mouth once a day for dementia with behavioral disturbances and a start date of 06/11/24. o Donepezil 10mg give one tablet by mouth once a day for dementia with behavioral disturbances and a start date of 06/11/24. o Quetiapine 25mg give one tablet by mouth once a day for dementia with behavioral disturbances and a start date of 06/11/24. o Lorazepam 1mg give one tablet by mouth twice a day for anxiety with a start date of 06/13/24. o Paroxetine 20mg give one tablet by mouth once a day for depression with a start date of 07/12/24. o Vistaril 25mg give 2 tablets by mouth every 8 hours as needed for anxiety with a start date of 08/12/24. o Do not send to ER without calling [hospice company] first with a start date of 06/06/24. o May transfer to [behavioral health facility] for evaluation with a start date of 08/14/24. Record review of Resident #1's elopement/wandering assessment dated [DATE], completed by RN F, indicated Resident #1 exhibited 1 or more high risk factors to wander, which indicated he was classified as a high risk to wander. The elopement/wandering assessment for Resident #1 indicated he had the following high-risk factors to wander: a history of wandering prior to admission to the facility, exhibited wandering behavior, resident followed others around, verbalized the need and or desire to go home or to another location and had the ability to act on that verbalization. The assessment indicated the intervention was the secured unit. The assessment also indicated Resident #1 did not know the location of his current residence. Record review of Resident #1's progress note dated 08/07/24 at 11:43 PM signed by RN F indicated . Resident awake and very agitated. Refuses to go to bed and keeps saying that he drove himself here in his mother's car, and that she will need it to drive to work in the morning. States that we are holding him against his will and has torn down all of the notes we had hanging up to remind him of why he was here. He says that his Dr did not put him here, and that he doesn't have a wife, He went to door at NS and shook it very hard, He also said he is going to sue this company, and burn it down, He says he does not mind going to jail, because that would be better than staying here. Sitting in recliner at NS at this time. Trying to redirect him we offered to call his wife for him, but he refused saying that we were lying to him about him having a wife. When I suggested we just call her and see if she answers and was adamant that he did not want me to call anyone. Record review of Resident #1's progress note dated 08/08/24 at 12:33 AM and signed by RN F indicated . Resident continues to escalate with his behaviors. He is shoving on doors and hitting them with his hand. DON notified and she asked if he had had his PRNs. I said yes and she said called [MD]. [MD] said send him to ER. EMS arrived and we talked him into getting on the stretcher by telling him he was going to get outside of these doors. EMS is gone with him. (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 Resident #1's progress note dated 08/08/24 at 4:30 AM and signed by RN F indicated . Resident returned from ER. Alert and ambulatory. Pacing and carrying his personal possessions with him. He is shadowing everyone that starts toward an exit door, and muttering something about he has to get home. We are monitoring him closely. Notified [hospice company] that resident was back in the building. Record review of Resident #1's progress note dated 08/08/24 at 6:17 AM and signed by RN G indicated . Resident exhibits increase agitation, approaches nurses station asking this write to leave facility. Resident noted to have personal belongings packed within personal reach. Writer attempts to redirect to other activities, currently unsuccessful at this time. Resident refusing vital sign checks and medication administration at this time. Will attempt to redirect and provide care as resident tolerates. Record review of Resident #1's progress note dated 08/08/24 at 08:00 AM and signed by RN G indicated . Resident continues to push on exit doors, making verbal demands to leave secured unit. Writer attempts to redirect resident to other activities, currently unsuccessful at this time. Resident continues to refuse foods, fluids, vital sign checks, and scheduled medication at this time. Will continue to attempt to redirect and offer care as resident tolerates. Record review of Resident #1's elopement/wandering assessment dated [DATE], completed by RN G, indicated Resident #1 exhibited 1 or more high risk factors to wander, which indicated he was classified as a high risk to wander. The elopement/wandering assessment for Resident #1 indicated he had the following high risk factors to wander: *a history of wandering prior to admission to the facility, *exhibited wandering behavior, *resident had on (1) or more occasions attempted to exit or has exited the facility in an effort to wander away, whether intentionally or due to confusion, *resident followed others around, *verbalized the need and or desire to go home or to another location and had the ability to act on that verbalization. The assessment indicated the potential interventions were secured unit, review medications, recreational activities, personalization of room with familiar objects and photographs, staff aware of resident's elopement risk, and staff aware of resident's wander risk. The assessment indicated Resident #1 did not recognize stop lights and signs, and he did not know precautions when crossing streets or the location of his current residence and was not able to recognize physical needs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Nursing and Rehab	910 S Beech St Winnsboro, TX 75494

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note dated 08/12/24 at 4:28 PM and signed by the DON indicated . Family and CNA reported to writer that resident is making threats to self-harm. Stating 'if I have to stay here, I am going to kill myself'. When staff attempted to redirect resident became agitated and threatened to kill staff member. Staff report Resident has been increasingly agitated, and hospice had been notified for med management. All attempts to redirection unsuccessful at this time. MD, family aware. Suggestion to send to behavioral health for safety needs at this time. [family member] at bedside and aware. Resident on 1:1 care at this time. Record review of Resident #1's progress note dated 08/12/24 at 6:42 PM and signed by LVN B indicated . at 15:00 (3:00 PM) resident went outside for scheduled break with CNA. At the end of the scheduled break at approximately 15:15 (3:15 PM) resident refused to come back inside. Resident then made threats to the CNA and continued to refuse to come inside. SN approached resident and asked him to come incident and resident then made references to self-harm. SN then contacted Hospice Services about resident escalating behavior. SN then contacted resident's RP who stated she would come up to the facility to talk with resident. RP arrived at approximately 16:45 (4:45 PM) and was able to talk to resident into coming back inside. Hospice nurse arrived shortly after and contacted MD and received an order for hydroxyzine 50mg PO Q8 hrs. PRN. Medication was administered at approximately 17:30 (5:30 PM). At approximately 18:00 (6:00 PM) resident is resting in bed with eyes closed, resident now has a one-on-one nurse to monitor for the remainder of this shift. SN will follow up. Record review of Resident #1's hospice visit note dated 08/12/24 at 11:54 AM completed by Hospice RN A indicated . Pt was sitting outside in the courtyard. He had just finished his lunch. He was pleasant. No complaints voiced. The nurse stated that earlier the pt refused to come inside and he had to work with him a long time to get him to come in. The [Resident #1's family member] stated when I spoke to her that he prefers to be outside. Pt was not anxious or agitated. Record review of Resident #1's elopement/wandering assessment with an observation date of 08/12/24 completed by the DON on 08/13/24, indicated Resident #1 exhibited 1 or more high risk factors to wander, which indicated he was classified as a high risk to wander. The elopement/wandering assessment for Resident #1 indicated he had the following high-risk factors to wander: *a history of wandering prior to admission to the facility, *exhibited wandering behavior, *resident followed others around, *verbalized the need and or desire to go home or to another location and had the ability to act on that verbalization. The assessment was answered No to the question asking if Resident #1 had on (1) or more occasions attempted to exit or had exited the facility in an effort to wander away, whether intentionally or due to confusion. The assessment indicated the potential interventions were secured unit, review medications, recreational activities, music, personalization of room with familiar objects and photographs, staff aware of resident's elopement risk, and staff aware of resident's wander risk. The assessment indicated Resident #1 did not know precautions when crossing streets, and he did not know the location of his current residence. (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 Resident #1's hospice client coordination note dated 08/13/24, indicated on 8/12/24 the following occurred: 15:03 (3:03 PM) received a call from [hospice staff] at the office that [LVN B] had called and said that [Resident #1] behavior was escalating. He is out in the courtyard and had removed his shirt, swearing and refusing to come inside. He asked the aide to kill him. 1514 (3:14 PM) I called [Resident #1's family member] and updated her and I was headed to the facility. [Resident #1's family member] said her and [another family member] would be there ASAP. 1545 (3:45 PM) I was driving south on [name] st on the way to the facility when I spotted [Resident #1] walking north. I turned around to keep a visual on him as I called [Resident #1's family member]. She was walking looking for him. [Resident #1's other family member] pulled up and got him in the car. 1600 (4:00 PM) updated [MD]. 1600 (4:00 PM) Pt is sitting in the lobby at the facility with [his family member]. He is always calm [with family member]. After meeting with staff and the family it was decided that the best action for the pt is for him to go to a behavioral unit bc he is a danger to himself. He has been discussing wanting someone to kill him. 1700 (5:00 PM) A bed will be available in the am. The facility placed with the pt 1:1 spoke with [MD]. New order received for hydroxyzine 50mg q 8 hrs PRN. Order written. Educated staff and family on new meds, actions and side effects. Staff is aware to call the emergency number with any questions changes or concerns. Record review of Resident #1's hospice discharge visit note dated 08/14/24 and signed by Hospice RN A, indicated under discharge summary . pt was admitted to hospice after a decline in physical status. admitted to [facility] memory care bc he was no longer safe at home. Pt did not do well at the facility. He eventually got out of the facility. Pt was sent to [behavioral unit]. Record review of the facility incident and accident reports from July 2024-February 2025 did not indicate any elopement incidents. During an interview on 03/03/25 at 09:53 AM, Resident #1's family member said the day of the incident (08/12/24), they received a call from the facility regarding Resident #1's behaviors. Resident #1's family member said they told the nurse they would return to the facility. Resident #1's family member said they called the hospice nurse to meet them there to see what could be done regarding Resident # 1's behaviors. Resident #1's family member said when they arrived at the facility, Resident #1 was not there. Resident #1's family member said the facility staff were unable to locate Resident #1. Resident #1's family member said no one at the facility knew Resident #1 was missing or how long he had been missing. Resident #1's family member said Resident #1 had escaped out the fence and the hospice nurse (unsure of name) found him 3 miles down the road past the middle school. Resident #1's family member said the hospice nurse was the one that followed him until they got there to get him in the car. Resident #1's family member said she wrote the facility a statement when they returned Resident #1 to the facility. Resident #1's family member said Resident #1 was being unmonitored by the facility staff. (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 03/03/25 at 10:47 AM, the Hospice Patient Care Manager said there had been an incident where Resident #1 climbed the fence and left the facility. The Hospice Patient Care Manager said Hospice RN A was on her way to the facility, Hospice RN A happened to turn to look at a person who was walking by, and realized it was Resident #1, so she turned around and followed him. During an interview on 03/03/25 at 11:37 AM, Hospice RN A said the day of the incident (08/12/24) she had been at the facility earlier that day and Resident #1 had been calm. She said she knew what Resident #1 was wearing that day. Hospice RN A said around 4:00 pm, she received a call from his nurse that Resident #1 was agitated. Hospice RN A said they had instructed the facility staff to call them with any behaviors because Resident #1's family member had the ability to calm him down. Hospice RN A said she told the facility she was on her way and then called Resident #1's family member. Hospice RN A said she had been on [name] street, a street close to the local pharmacy, when a longhorns shirt caught her eye. She said she turned to look and realized it was Resident #1. She said, There goes my patient. Hospice RN A said she turned around and called Resident #1's family member. Hospice RN A said Resident #1's family member was screaming we can't find him. She said she told her she knew where Resident #1 was, and they came and got him. Hospice RN A said Resident #1 was placed on one on one when he returned to the facility, and he was sent to a behavioral hospital on 08/14/24. During an observation on 03/03/25 at 12:25 PM, the middle school was observed to be located north of the facility, approximately 0.5 miles crossing a busy 2 lane road. During an interview on 03/03/25 12:43 PM, LVN B said he was no longer employed at the facility but had worked the secure unit on the 2:00 PM - 10:00 PM shift. LVN B said Resident #1 had not eloped on 08/12/24. LVN B said he had eyes on Resident #1 the whole time. LVN B said Resident #1 was the resident that did not want to come back inside. LVN B said Resident #1 was hard to handle, but he had not run away that he was aware of. He said Resident #1 was placed on one-on-one monitoring due to his behaviors. LVN B said he was unsure of who sat with him, since management did that. He said he notified hospice regarding Resident #1's behaviors. He said if he had a resident who eloped he would notify the supervisor and follow the facility's protocol, call the MD, call the family and call 911, if the resident was out of sight. During an interview on 03/03/25 at 2:19 PM, CNA C said she had been working in the secure unit on 08/12/24. CNA C said she remembered Resident #1's family member visited with him the morning of 08/12/24. CNA C said Resident #1 wanted to go home with his family member, and he wanted to go out of the facility. CNA C said they took Resident #1 out to smoke in the secured smoking area by the unit around 3 PM. CNA C said when Resident #1 went outside to smoke they could not get him back inside the facility, and he refused to go back into the facility. CNA C said she kept an eye on him and at one point he hid behind a tree. She said all of a sudden, she could not see him. CNA C said they found him close unsure of location. She said the Maintenance Supervisor was out looking for him, and she was unsure of who else. CNA C said she was keeping an eye on Resident #1 by peeking through the door occasionally after providing care to other residents. CNA C said she reported to the charge nurse Resident #1 was no longer outside and he alerted everyone else. CNA C said the charge nurse was also keeping an eye on him. CNA C said they thought fresh air would help him with his behaviors. She said she never imagined Resident #1 would climb over the fence. CNA C said if she had a resident that voiced wanting to leave or trying to elope, she would notify the DON and charge nurse and not take the resident outside. (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 03/03/25 at 2:29 PM, the SW on 8/12/24, she knew that a staff member followed him (unsure of who) down the street. She said she did not know how far he went or who brought him back. The SW said Resident #1 was sent to a behavioral hospital first, and then to another facility. During an interview on 03/03/25 at 2:30 PM, the DON said Resident #1 did not elope because he was followed by the ADON. The DON said Resident #1 was walking down the road by the school. The DON said when Resident #1 was in the facility's parking lot he told the ADON he was not getting in the car. The DON said the ADON followed him until the family got there. The DON said family and hospice was called and they were on the way to the facility. The DON said they provided staff with elopement in-services and completed elopement assessments for all residents in the secure unit. The DON said they in-serviced staff because had the ADON not been out there to see him, it would have been an elopement and there could have been a worse outcome. During an interview on 03/03/25 at 2:31 PM, the Administrator said the day of the incident the ADON was with Resident #1, and he did not want to get in her car. She said she did not remember how far he had gone but believed it was by the mobile home park in front of the facility. The Administrator said she was unsure if Resident #1 had voiced he wanted to leave. The Administrator said she expected when a resident eloped or was trying to elope that they get them back in the facility safely. She said they had educated staff if a resident was not found a code pink (missing resident) should be called, the police should be notified, and everyone for all hands-on deck for a successful trip back home. During an interview on 03/03/25 at 2:36 PM, the ADON said Resident #1 did leave the facility. The ADON said she was outside in her car on 08/12/24 and saw Resident #1 climb the fence. She said she had tried to get him in the car, but he refused. She said she followed him at a safe distance in her car. The ADON said Resident #1 walked straight and crossed the road toward the school. The ADON said the family met him where we were and brought him back to the facility. The ADON said she had called the DON. The ADON said they had called hospice and family to let them know Resident #1 had been trying to beat up the staff, and Resident #1's family was headed to the facility. The ADON said she was unaware of who all knew but the DON knew I was following him. The ADON said if Resident #1 had actually eloped, the DON and Administrator would have notified all channels, family, and MD. The ADON said it was best to keep eyes on him. During an interview on 03/03/25 at 2:56 PM, Hospice RN A said the SW found him right after she did, and the SW had made eye contact with her. She said she did not recall if the ADON was at the site where Resident #1 had been picked up. During an interview on 03/03/25 at 3:03 PM, Resident #1's family member said there was no facility staff at the site where Resident #1 was found that they were aware of. Resident #1's family member said the hospice nurse told them she was on [name] street. Resident #1's family member told the hospice nurse he was not going to get in her car with her because he did not know her, and they did not want the hospice nurse to set him off. Resident #1's family member said she walked to him and the other family member drove. Resident #1's family member said the facility staff had no clue he was missing. (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 03/04/25 at 09:05 AM, the Regional Director of Operations said he had asked the ADON if she had provided a written statement to the surveyor regarding the incident that occurred on 08/12/24. The Regional Director of Operations said the ADON told him they did not provide a written statement to the surveyor. The Regional Director of Operations said he had asked the ADON if she had her phone with her that day and she said she did and that she had called the DON. He said LVN B was also keeping an eye on Resident #1 by looking out through the door of the secure unit.

During an interview on 03/04/25 at 10:06 AM with the Regional Director of Operations, Regional Nurse Consultant, the Administrator, the DON, and ADON, the DON said she had spoken to [LVN B] that morning and he had told her it was not considered an elopement if it was witnessed. State Surveyor questioned how come the incident was not documented anywhere in Resident #1's electronic medical record, and the DON said she had educated [LVN B] on documentation and he had walked off when they were trying to educate him. The DON said LVN B said, he was not going to work like this and left. State surveyor questioned how come no other staff member went to assist the ADON, the DON said she went out the front door and did not see him, and she called hospice and the family. The DON said the family did not answer. The DON said they did not go because Resident #1 was being belligerent, to not make the situation worse and the ADON was already in her car and was following him. The ADON said she did not see Resident #1 jump the fence she saw him outside the fence. The DON said the family had not arrived at the facility prior to the incident and the family was seen when they were bringing him back to the facility. The DON said the family had told the Administrator and herself that they had seen the ADON in her car. The DON said when she became aware of Resident #1's negative statements, he was placed on one on one.

Record review of a typed statement provided on 03/04/25 at 10:25 AM signed by the ADON and dated 08/12/24, indicated . I, [ADON's name], witnessed [Resident #1], walking outside the fenced area toward the parking lot at approximately 1615 (4:15 PM). Staff nurse was at opened glass door of courtyard visualizing resident as I approached him on foot in attempt to get him to return to the facility. He became physically and verbally aggressive stating that if I did not leave him alone, he would kill me. I got back into my car to follow beside him until other help arrived. I phoned the facility to ensure they were aware of what was happening. My car remained on the left and he was on the right. There was no oncoming traffic. [Resident #1] paused before crossing the highway while continuing to yell at me to stop following him. I continued to follow until the family arrived in their vehicle and persuaded him to get into their car. I at no time lost eyesight of resident, until he was placed in his private family car. The resident returned to the facility at approximately 1625 (4:25 PM) and was escorted back into the secured unit by family and DON and placed on 1:1 care.

Record review of a typed statement provided on 03/04/25 at 10:25 AM signed by the DON and dated 08/12/24, indicated . Writer spoke to nurse [LVN B] to obtain statement of incident. [LVN B] stated he had been watching [Resident #1] on the courtyard and attempted to re-direct him back inside. He became belligerent so he stood at a safe distance in the doorway. When he walked away from the door, he ensured another staff member was present. [LVN B] stated he did not feel this was an elopement based on the fact the incident was witnessed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 03/04/25 between 10:30 AM and 12:15 PM with (RN G, CNA L, Maintenance Assistant M, Director of Rehabilitation O, CNA N, LVN P, CNA Q, Housekeeping R, LVN S, LVN T, CNA U, LVN V, CNA W, Dietary Aide X, CNA Y, LVN Z, LVN AA, CNA BB, the Maintenance Supervisor, the ADON, COTA, MDS Coordinator, Activity Director and the Dietary Manager) revealed they were able to answer questions regarding abuse and neglect in-service, who to contact, when to contact and types of abuse. Staff was able to answer questions on elopement in-service regarding code pink, immediately contacting the Administrator and DON, searching facility on and off grounds, and calling the police if resident was not found within 30 minutes. During an interview on 03/06/25 at 09:55 AM, CNA H said she had worked on 08/12/24. She said she recalled Resident #1 being restless, had gotten out, and had walked down the road. She said everyone was looking for him. During an interview on 03/06/25 at 12:23 PM, LVN B said Resident #1 went outside and he had eyes on him at all times. He said he alerted management and DON when Resident #1 was outside of the fence, and they handled everything after that. LVN B said he had the back door open and contacted the DON by phone. LVN B said he was not sure if Resident #1 left the facility property. LVN B said he continued with his duties since he had other residents to take care of. He said the Maintenance Supervisor and the SW assisted with bringing him back. LVN B said he did not receive any education on documentation that he could recall. He said the facility staff tried to blame him for the incident that was why he became upset at them. He said he had kept them in the loop of Resident #1's behaviors. During an interview on 3/6/25 at 12:46 PM, the Maintenance Supervisor said the day of the incident, 08/12/24, someone (unsure of who) had asked him if he had seen Resident #1. He said he then started to coordinate people and started looking for him. He said he was able to get on the intercom with his phone and announced Resident #1 was missing. He said he helped the family bring him back from their car. He said to his knowledge, Resident #1 was missing. He said people left in their cars to search off ground. During an interview on 03/06/25 at 1:28 PM, the SW said there was a mass text indicating the ADON was following Resident #1. She said she had just gotten back to the facility, got back in her car and when she got to where Resident #1 was, which was by the school, Resident #1's family members were talking to him and were getting him in the car. She said they brought him back to the facility. The SW said she saw the hospice nurse in her car by the school as well. She said they spoke to each other. She said there was no mention that Resident #1 was missing. She said the ADON was with him and had had eyes on him. During an interview on 03/06/25 at 2:20 PM, CNA C said no one was constantly with Resident #1 on 08/12/24. She said the nurse was the one that did not see him, and he started calling the Administrator and putting the alert out that he was not where he was supposed to be. She said everyone started looking. CNA C said they did not know which direction he had gone but he had not gone very far. Record review of the elopement assessments completed for the 15 residents who resided in the secure unit were dated 08/13/24 and 08/14/24. Record review of 13 resident safe assessments completed on 08/12/24 with no concerns noted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Whispering Pines Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 910 S Beech St Winnsboro, TX 75494	

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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	Record review of 13 employee (CNA DD, CNA EE, LVN FF, LVN Z, CNA GG, CNA N, CNA L, [NAME] HH, LVN KK, the Treatment Nurse, MA LL, [NAME] MM, and the Dietary Supervisor, abuse and neglect questionnaire completed on 08/12/24 indicated staff was able to answer who to report abuse and neglect, when to report abuse or neglect, and the types of abuse. Record review of the in-services dated 08/12/24, indicated staff was in-serviced on elopement, code pink, best practice if a resident cannot be located, immediately contacting the Administrator, DON, regardless of the time or day of the week, and it was imperative to have sense of urgency in order to ensure resident safety, abuse and neglect, immediately contacting the Administrator, and types of abuse. Record review of weekly monitoring indicated Administrator/designee will interview 2 staff members a day 5 times a week for 4 weeks with a start date of 08/12/24 and end date of 09/06/24 had been completed. Record review of facility's policy Elopement with an effective date of 12/2017 indicated: Policy It is the policy of this home to provide a systematic approach to searching for a resident who may have left the home and/or home grounds. PROCEDURE The following steps are to be followed when a resident is noted absent and is not found on initial search of the home. This also includes when a resident leaves the home grounds without staff notification. Home Staff will: o Search the home and grounds o Send staff member(s) out to locate the resident o Notify Administrator or on-call person immediately o If resident is not located within 30 minutes, call the local police Charge Nurse will: o Notify responsible party (this may be done when the search is initiated) o Notify the resident's physician o Assess the resident on return to the home o Document the time resident absence is noted, time of return, assessment of resident, and notification of Physician and Responsible Party (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675812	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Complete an incident report in the clinical software o Follow-up charting for 24 hours if no injuries: follow-up charting on injuries until resolved Administrative I Supervisory Staff will: o Determine if elopement is reportable to state regulatory agency o Interview staff and obtain written statements. If