STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675939	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vintage Health Care Center	205 N Bonnie Brae Denton, TX 76201

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** 42824 Based on observations, interview, and record review, the facility failed to ensure resident received adequate monitoring, supervision, and/or assistive devices to prevent accidents for 1 of 8 residents (Resident #1) reviewed for accidents, hazards, and supervision. On 03/07/2025, the facility failed to identify potential hazards and follow internal systems in place to prevent Resident #1's elopement from the facility approximately two hours and twenty minutes after his admission. He was located approximately two hours later by local law enforcement approximately 1 mile east of the facility. A Past Non-Compliance Immediate Jeopardy (PNC IJ) was identified and presented to the Administrator on 04/17/2025 at 4:24 PM. The noncompliance began on 03/07/2025 and ended on 03/07/2025. The facility corrected the noncompliance before the investigation began . This failure could place residents at the facility at risk of injury and a decreased quality of life due to the lack of supervision and care that residents need to be safe. Findings Included: Review of Resident #1's Face Sheet, dated 04/17/2025 revealed he was a [AGE] year-old male admitted on [DATE]. Relevant diagnosis included dementia. Review of Resident #1's Baseline Care Plan, completed after his elopement, dated 03/07/2025 revealed he was and/or had: -At Risk for falls -Impaired cognitive function related to dementia -Required antidepressant and antipsychotic medication -ADL self-care performance deficit -At risk for wandering and had history an elopement at the facility on 03/07/2025 (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	Review of Resident #1's Admission MDS, completed after his elopement, dated 03/07/2025 revealed he admitted from a short-term general hospital. No other relevant information was stated. Attempts were made to interview Resident #1 on 04/17/2025 at 10:00 am and 2:00 pm were not successful. In an interview with facility's ADON on 04/17/2025 at 1:00 PM, he revealed he was assisting with Resident #1's admission on 03/07/2025. He stated that Resident #1 was admitted at approximately 12:00 PM that day and was alert to self and his location but had intermittent confusion. He stated he oriented Resident #1 to his room and then directed the resident to the dining area for lunch. He stated after lunch at approximately 2:20 PM, Resident #1 was seen at the north nurse's station talking to another resident. He stated Resident #1 did not appear to be in any distress at this time, did not voice to him that he wanted to leave, and did not seem confused as to where he was located. When Resident #1 was observed in his room, he was unpacking his belongings into the facility's closet and armoire. The ADON stated at approximately 3:00 PM, Resident #1 could not be located and a code orange [indicating a missing resident] was implemented. Around approximately 5:00 PM local law enforcement reported to the facility Resident #1 was located and was returned to the facility at approximately 5:30 PM. Upon Resident #1's return to the facility, he was thoroughly assessed and appeared the same from admission, was not in any distress , and upon interview he reported to him that a friend gave him a ride to somewhere but could not state any further specifics. The ADON stated he did not state how he exited the facility and was not harmed per assessment. The ADON stated the resident was placed on 1:1 supervision in the secured unit and was transferred to a sister facility by approximately 7:00 PM that evening. He stated it was important to keep residents in the facility for proper monitoring, care, and supervision. In interview with the facility's DON on 04/21/2025 at 1:28 PM, she stated she was not present for this incident, but she stated it was important to keep residents in the facility for proper monitoring, care, and supervision. In interview with the facility Administrator on 04/17/2025 at 1:13 PM, he stated he was not present at the time of the elopement but responded to the event afterwards. He stated it was important to keep residents in the facility for proper monitoring, care, and supervision. The Administrator further stated that he and his leadership team reviewed Resident #1's pre-admission clinical documents and nothing seemed concerning related to wandering and/or elopement. He stated that if he did see any concerning information related to the resident's wandering risk, he would not have admitted Resident #1 because the secured unit at the facility was female-only. He stated that the resident was not present at the facility long enough for his staff to complete all the admission assessments required. He stated his expectations were for the admission assessments to be completed within four hours of admission. He stated that Resident #1 eloped from the facility within two hours and twenty minutes of his admission. The administrator stated that the post-elopement interventions for Resident #1 included: -Physician and responsible party notification -Head-to-toe assessment completed and no injuries noted -Trauma-informed assessment completed and no trauma noted (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Elopement risk assessments were immediately reviewed for all residents at the facility -Exit doors reviewed and inspected to be in working order -All resident care plans reviewed for high-risk for elopement residents -In-services to staff related to the incident were provided -A sign was placed at the skilled nursing entrance instructing families to ensure residents do not exit building -A hinged transparent cover on top of the green exit button was installed so someone with cognitive limitations would have a harder time locating it to prevent future elopements -Upon his return to the facility, Resident #1 was placed in the secured unit under 1:1 supervision prior to his transfer to a co-ed secured unit at a sister facility later that evening. In observation on 04/17/2025 at 1:00 PM with facility's ADON, facility exit doors were tested and inspected to be in working order, a sign located on the skilled nursing entrance that stated to ensure residents do not exit the building was observed, and a hinged, transparent cover was observed on top of the green exit button by the facility's entrance and exit doorway. Record review of facility's elopement drill, Internal Disaster Drill Form, dated 03/07/2025 at 3:00 PM provided by the facility's ADO revealed signatures from staff from all disciplines, departments, and shifts revealed Real Event, Missing Resident, police department was involved, and the duration of the drill was 2 hours. The narrative was listed as [Police Department] notified to assist in finding missing resident . Found approximately 5:00 PM. Record review of facility's In-service Trainings, Identifying at Risk Residents and Assessments, Elopement Policy and Procedure, One on one door monitoring, and Abuse and Neglect, dated 03/07/2025 provided by the facility's ADO revealed multiple signatures from staff from multiple disciplines, departments, and shifts covered. Education provided included: Identifying at Risk Residents and Assessments -Elopement risk assessment protocol -Assessments are for people that score above a 10 on elopement assessments -Staff are to be familiar with the resident's care needs and risk for wandering and elopement -Clinical staff are responsible to ensure assessments are completed and safety measures are in place and implemented Elopement Policy and Procedure (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Every effort will be made to prevent elopement while maintaining the least restrictive environment for residents at risk or elopement -Clinical staff are required to assess residents for elopement risk and ensure safety measures are in place and implemented -Code Orange Procedures and delegation of roles, tasks -How to identify the cause of wandering -Intervention strategies that include: reducing discomfort, labeling residents room clearly, maintain a resident's routine, schedule ambulation and toileting, and reducing excess stimulation One on one door monitoring -Staff are required to monitor of and document on resident at all times until monitoring is discontinued Abuse and Neglect -Definition of abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion -Procedure for reporting any abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion to the abuse coordinator -Leadership is required to conduct a comprehensive investigation for all allegations abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview with multiple staff over multiple disciplines, departments, and shifts included Administrator, ADO, CC, DON, ADON, SW, AD, [NAME] I, [NAME] J, [NAME] K, DA L, HSK M, HSK N, HSK O, CNA C, CNA D, CNA E, CNA F, CNA G, CNA H, and LVN B between 04/17/2025 and 04/21/2025 between 9:00 AM - 5:00 PM, they stated information related to their discipline that included how elopement risk assessment protocol relates to their job role, clinical staff were able to report that a resident is considered high risk when they score above a 10 on an elopement assessment, staff are required to be familiar with the resident's care needs and risk for wandering and elopement, clinical staff are responsible to ensure assessments are completed and safety measures are in place and implemented, that every effort will be made to prevent elopement while maintaining the least restrictive environment for residents at risk or elopement, clinical staff are required to assess residents for elopement risk and ensure safety measures are in place and implemented, reported information related to Code Orange and delegation of roles, how to identify the and causes/triggers of wandering, and intervention strategies that include: reducing discomfort, labeling residents room clearly, maintain a resident's routine, schedule ambulation and toileting, and reducing excess stimulation. Additionally, relevant staff reported they are required to monitor and document on resident at all times after an elopement or wandering behaviors are exhibited until monitoring is discontinued. Finally, staff were able to report the definition of abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion, the procedure for reporting any abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion to the abuse coordinator, and that leadership is required to conduct a comprehensive investigation for all allegations abuse, neglect, exploitation, misappropriation of property, mistreatment, and involuntary seclusion. Staff confirmed an elopement drill was conducted on 03/07/2025 and that Resident #1 was transferred to a secured unit the same day of the incident. In review of facility policy, Elopement Prevention, dated 01/2023 revealed Every effort will be made to prevent elopement while maintaining the least restrictive environment for residents at risk or elopement . 1. The Elopement Risk Assessment will be completed upon admission . the assessment tool should be completed, and interventions implemented as indicated. The Elopement Risk Assessment is to be completed at least quarterly, after an elopement attempt, upon new exit seeking behavior, and upon change of condition.