STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675960	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Pines Health and Rehabilitation	2414 W Frank Ave Lufkin, TX 75904

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** Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision to prevent elopement for 1 of 1 (Resident #1) resident reviewed for supervision. The facility failed to keep Resident #1 in a safe environment to prevent an elopement on 3/23/26 when he walked out the front door of the facility.The non-compliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began 3/23/26 and ended on 3/24/26. The facility corrected the non-compliance before surveyor's entrance.This failure could place residents at risk of not being properly supervised resulting in injury or death.Findings included: Record review of the electronic face sheet indicated Resident #1 was a [AGE] year old male originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnosis that included: malignant neoplasm of the brain (brain cancer), hyper lipidemia (high cholesterol), seizures, carcinoma (cancer) in bronchus and lung, nicotine dependance, depressive disorder, and hypertension (high blood pressure). Resident was also receiving Hospice care. Record review of Resident #1's admission MDS assessment dated [DATE] indicated a BIMS of 00, which indicated severe cognitive impairment with inattention and disorganized thinking. The MDS also indicated Resident #1 had no wandering behavior. Record review of Resident #1's care plan dated 12/29/25 indicated the following: - Resident #1 had impaired cognitive function or impaired thought processes. Interventions included: Administer meds as ordered, communicate with the resident/family/caregivers) regarding residents capabilities and needs, Discuss concerns about confusion, disease process, NH placement, with the resident/family/caregivers. -Resident #1 was at risk for wandering. Interventions included: assess for fall risk, distract resident from wandering by offering diversions, structured activities, food, conversations, identify patterns of wandering: is it purposeful, aimless or escapist. Record review of Resident #1's care plan dated 3/23/26 indicated the following: -Resident #1 was at risk for elopement as evidenced by resident is ambulatory and has altered mental status at times. Interventions included: Resident placed on 1:1 for actual elopement, seek alternate placement for secured unit. Record review of Resident #1's elopement risk assessment dated [DATE] indicated an elopement score of 20 which was of high risk category.Record review of Resident #1's elopement risk assessment dated [DATE] indicated an elopement score of 20 which was of high risk category.Record review of Resident #1's elopement risk assessment dated [DATE] indicated an elopement score of 19 which was of high risk category. Record review of an event note dated 3/23/26 and signed off by LVN M indicated Resident #1 exited out the front door, was gone 20 minutes and found at the apartment complex next to the facility. Resident #1 reported he was going to his mom's house. Cognition/behavior at the time of the event: cognitive impairment, wanders, exit seeking. Nurse description of the event: this nurse was notified by other charge nurse that she thought she saw the Resident walking near the road while she was outside on break. This nurse initiated a search of the Resident's room and did not find him. Officers arrived to the facility in response to a call from the Resident. Elopement protocol initiated and a search of the facility and immediate ground was completed. The Resident was located and returned to the facility immediately by officers. Initial treatment and or new orders was one on one (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	monitoring. Nurse Practitioner and responsible party notified. All exit doors were checked for proper functioning and all found to be in working order.Record review of an Elopement and Risk Assessment Report indicated risk assessments were initiated on 3/24/26 on all residents. Record review of the timeline dated 3/23/26 provided by the DON of camera footage revealed the following:6:12 p.m. LVN L went outside,6:22 p.m. Resident #1 seen leaving the facility,6:25 p.m. LVN L returned to the facility,6:31 p.m. staff members noted to go outside,6:34 p.m. police entered facility, and6:55 p.m. Resident returned to facility with police. During an observation on 5/13/26 at 9:05 a.m., the front entrance door to the facility had a large green sign on the inside and outside that said: All Visitors-Please do not allow residents to exit the building unless it is your family member and you have notified staff. During an interview on 5/13/26 11:50 a.m., the DON stated Resident #1 was standing at the front doors looking out around 6:22 p.m. on 3/23/26. Stated a female visitor punched the code to enter, and Resident #1 held the door open for and went out after she came in. The DON stated around 6:12 p.m. LVN L had gone outside on a smoke break and saw a man come out of the facility walking across the grass but could not tell who it was but thought it was Resident #1 . After talking with other staff, and a search in the facility, it was determined to be him. The DON stated Resident #1 left the building around 6:22 p.m. on 3/23/26, and when the facility called the police they were told they had already been notified by Resident #1 who told them the facility was holding him hostage. Staff drove over to the apartment complex next door and located Resident #1 who would not return to the facility with them. Resident #1 said he went to visit his sister (who had previously lived there for 9 years, and Resident #1 and his mother would visit her). Resident #1 told the police he was not going back because they were holding him hostage. Police finally talked him into coming back after about 10 minutes. The DON stated the police arrived around 6:45 p.m. to the Resident's location and returned to the facility at 6:55 p.m. The DON stated Resident #1 did not have dementia but had a brain tumor and had never attempted to elope prior to this incident. Stated all exit door alarms were checked and found in working order, Resident #1 was placed on 1:1 and transferred to another facility the next day. The DON stated on the elopement risk assessments, anything over a score of 10 triggered for high risk and there had not be any other elopements in the facility. During an interview on 5/13/26 at 1:00 p.m., the Administrator said that on 3/23/26, the resident made the choice to go visit his sister who had lived in the apartment complex next door to them. Stated after the incident a sign was placed on the inside and outside of the entrance door in bright green that said: All Visitors-Please do not allow residents to exit the building unless it is your family member and you have notified staff. The Administrator said they did not admit residents felt to be flight risks. Stated Resident #1 had not attempted to get out of the facility before this incident. Stated if they noticed any patterns of exit seeking with a resident, or if a resident says they are going to leave the facility they would have a care plan meeting to look at alternate placement. Administrator stated Resident #1 was steady on his feet, and you couldn't really tell he was a resident most of the time. Stated Resident #1 had a friend that came to the facility and would take Resident #1 out to smoke in his vehicle off the premises, as smoking was not allowed. Stated the nurse who went out to smoke the day of the incident, was on the other side of the facility premises and was not sure if it was Resident #1 she saw walking in the grass or not as it was quite a ways away. On the date of the incident, Administrator stated Resident #1 exited the facility when a visitor and punched the key code in and opened the door. Stated as she opened the door, he held it for her and when she came in, he went out. Stated inservice training was initiated after the incident, and Resident was placed 1:1 until he was transferred out the next day. Stated all door alarms were checked and in working order and elopement risk assessments done on all residents. During an interview on 5/13/26 at 1:20 p.m., CNA C stated she had taken care of Resident #1 while he was on 1:1 monitoring, and that he was sweet and non-combative. Stated he had good days and bad days with his memory. Stated Resident #1 told her that he had cancer, and it had spread all over. Stated Resident #1 would walk around the facility quite a bit, and the only time she had seen him wanting to leave was when his sister was leaving and he wanted to go with her. CNA C (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated the sister would take him out on pass at times. Stated she had never seen him try to go out any of the doors. Said his gait was usually fairly stable. Stated he would walk to the dining room for meals and was friendly to everyone. CNA C stated Resident #1 told her that his sister lived in the apartments next door and he was trying to go visit her. During an interview on 5/13/26 1:32 p.m., MA A stated she had never seen Resident #1 go to an exit door or try to get out. Stated Resident #1 would go to the dining room and back to his room, and his gait was steady when she had observed him. MA A stated Resident #1's sister would come get him and take him on outings once in a while, but he usually stayed in his room or was in the dining room. MA A stated she had never seen him go to the door unless he was going out with his sister. During an interview on 5/13/26 at 1:36 p.m., CNA D stated Resident #1 always wanted to go home with his sister, and the sister would take him out once in a while, otherwise he would stay in his room most of the time. CNA D stated Resident #1 would get up and go to the dining room or go get coffee, but she had never seen him just wander around the halls. CNA D stated some days Resident #1's memory was good, other days it was a little off. During an interview on 5/13/26 at 1:44 p.m., LVN L stated on the day of the incident, she had gone outside on break about 6:10-6:15 p.m. Stated she went to the end of the facility property line by the trees to smoke and she saw someone walking across the facility grass. Stated she thought it looked like Resident #1 but was not 100% sure, and the person was walking fast, and it was quite a distance from where she was. Stated she immediately came back to the facility and notified the other staff working. Stated the police arrived shortly after she came back in before they could even call them. Stated the police told them that Resident #1 had called them. Stated she did not remember what they said as to what Resident #1 told them when he called. Stated she did not know what transpired after the police talked to the staff, but Resident #1 was brought back to the facility. LVN L stated she had never seen Resident #1 try to get out of the facility before. During an interview on 5/13/26 at 1:59 p.m., LVN P stated she was working the day of the incident with Resident #1. Stated around 6:30ish, LVN L, the nurse on hall 500 came to her and another nurse. LVN P stated she thought she saw someone who looked like Resident #1 walk outside while smoking. LVN P stated both nurse aides and med aides looked for Resident #1. LVN P stated the police had showed up at the facility at that time. Police had asked if he had been found. Staff told them what happened and they all went to the apartment building next to the facility. LVN P stated that around 15-20 minutes later police came back with Resident #1. LVN P stated she thought Resident #1 was gone for about 20 minutes. LVN P stated she had never seen Resident #1 try to get out or even asked to get out. Stated Resident#1 was alert and oriented x 3 with intermittent confusion. LVN P stated it was about 5 minutes after they found out about the incident that the police came. During an interview on 5/13/26 at 2:23 p.m., LVN Q stated Resident #1 had been admitted to the facility prior. Stated on both admits his BIMS scores were 0 due to inattention, and disorganized thinking. Stated Resident #1 had never tried to get out of the facility that she knew of prior to this. Stated he was care planned for wondering, which he did walk around the halls aimlessly at times, but never attempted to elope. During an interview on 5/14/26 at 12:20 p.m., the DON stated there had not been any indications that Resident #1 would go out the door. Stated Resident #1 did not show any signs of exit seeking and had not voiced any concerns that he wanted to leave or go home. Stated he did nothing to make us think he was going anywhere. The DON stated Resident #1 engaged and interacted with the staff appropriately. The DON stated all families/responsible parties were contacted by email or phone call asking them to not allow residents to exit the building unless it was their family member and they had notified the staff or phone call on 3/24/26. During an interview on 5/14/26 at 1:28 p.m., ADON O stated she felt staff acted appropriately when they found Resident #1 was missing. Stated inservice training was started immediately after the incident, and elopement risks were done on all residents. During an interview on 5/14/26 at 1:34 p.m., the Administrator said she felt the facility had done everything they could to protect Resident #1, and everything was put into place; the documentation, the assessments, new interventions, and they followed all their protocols to ensure residents are not exit seeking by doing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	elopement assessments on all residents, and moving Resident #1 to an environment suited for him. During an interview on 5/14/26 at 1:41 p.m., ADON N stated she had helped with staff education after the incident. Stated they would hide residents who were willing to participate, and the staff had to follow procedure till they were found. Stated the staff were very receptive to the education. Record review of a facility policy titled Elopement Response with a revision date of 1.2026 revealed the following: .nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred the elopement response plan will be immediately implemented.should an employee discover the resident is missing from the facility they should: report to charge nurse, make a thorough search of the building and premises. The interventions and plan for correction included: 1. Record review of a Discharge Summary for Resident #1 dated 3/24/2026 indicated he discharged from the facility on 3/24/2026 to another nursing facility.2. Record review of an event nurses' note dated 3/23/2026 at 6:30 pm by LVN M indicated Resident #1 Hood eloped from the facility and was placed on 1:1 monitoring. All exit doors checked for proper functioning. All found to be in working order.3. Record review of elopement risk assessments for the facility dated 5/14/2026 indicated all 95 residents in the facility had elopement risk assessments that were completed on 3/24/2026 with the exception of new admissions that were completed on their admission dates after 3/24/2026.4. Record review of family notifications dated 3/24/2026 by the BOM Assistant indicated an email was sent to the RP's that stated, Please do not allow residents to exit the building unless it is your family member and you have notified staff.5. Record review of 1:1 in-services on elopement prevention, elopement response and abuse/neglect was provided to the DON and Administrator by the Regional Nurse.6. Record review of Medical Director notification of the immediate jeopardy citation was on 5/13/2026.7. Record review of an Ad Hoc QAPI meeting was held on 5/13/2026 to discuss an identified immediate jeopardy related to accidents and supervision.8. Record review of an inservice dated 3/23/2026 on elopement response by the DON indicated 91 staff were in attendance of the training and the training was ongoing as of 5/14/2026.Record review of an inservice dated 3/23/2026 on if you see a resident elope what to do by the DON indicated 88 staff were in attendance of the training and training was ongoing as of 5/14/2026.Record review of an inservice dated 3/23/2026 on abuse/neglect by the DON indicated 86 staff were in attendance of the training and training was ongoing as of 5/14/2026.Record review of an inservice dated 3/23/2026 on resident rights by the DON indicated 100 staff in attendance of the training.Record review of an inservice elopement prevention, abuse/neglect and resident rights for new hires after 3/24/2026 by ADON N and ADON O indicated 13 staff in attendance of the training from 3/25/2026 to 5/1/2026.During an observation on 5/14/2026 at 9:15 am, signage at front door for visitors to ask staff prior to letting any residents out. Front door locked and sign indicated to press button to get into the facility.During a phone interview on 5/14/2026 at 10:57 am, RP of Resident #5 said she was made aware of the signage at the front entrance to not let residents out without staff knowledge.During an interview on 5/14/2026 at 11:20 am, the RP of Resident #6 said he visited daily. He said he was contacted about a month ago about not letting residents out with him when he left. He said this morning when he arrived he had to push the button for them to let him in the facility.Attempted a phone interview on 5/14/2026 at 11:30 am, the RP of Resident #7 was unable to leave a voicemail message due to the mailbox being full.Record review of a progress note dated 3/24/2026 at 11:04 am, by the ADON N to the RP of Resident #7 indicated .Called emergency contact at this time to inform them to please not open the door or let anybody out of any of our exit doors to keep our resident's safe. Ensure that if they are taking any residents out to sign them out and let the charge nurse know beforehand. During interviews on 5/14/2026 from 11:36 am to 1:47 pm staff from different shifts included: CNA B, CNA C, CNA D, DOR, LVN E, PT, HSK F, DA G, LVN L, and LVN P: staff were able to verbalize if saw a resident that was trying to leave the facility and would intervene and try to turn them around and let the nurse know and get the resident to safety. If a resident was wandering and trying to go to the door would redirect them. They verbalized if a resident was missing, report a code orange, would notify the charge nurse (continued on next page)

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