STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675962	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 7 residents (Resident #3 and Resident #7) reviewed for resident rights. 1.The facility failed to ensure CNA Z did not speak degradingly to Resident #3 during personal care on 2/19/24. 2.The facility failed to ensure CNA G did not tap the hand of Resident #7 in a degrading manner during personal care on 6/29/24. These failures placed residents at risk of decreased feelings of self-worth and decreased quality of life. This was determined to be past noncompliance due to the facility having implemented actions that corrected the noncompliance prior to the beginning of the survey on 6/29/24. Findings include: 1.Record review of a facility face sheet dated 8/20/24 for Resident #3 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Arthritis (swelling and tenderness of one or more joints), dysphagia (difficulty swallowing that can be caused by various conditions affecting the throat or esophagus), dementia (a group of symptoms affecting memory, thinking and social abilities), and type 2 diabetes mellitus (a condition that affects how the body uses sugar as a fuel). Record review of a Quarterly MDS assessment dated [DATE] for Resident #3 indicated that she had a BIMS score of 5, which indicated that she had severe cognitive impairment. She was dependent with toileting and personal hygiene. She was always incontinent of bowel and bladder. Record review of a comprehensive care plan dated 1/9/24 for Resident #3 indicated that she had an ADL self-care deficit related to impaired cognition and dementia, poor mobility, weakness, and incontinence. Interventions included to converse with resident while providing care, and to explain all procedures/tasks before starting. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an attempted telephone interview with CNA Z on 8/20/24 at 2:59 pm a message was received that number was no longer in service. During a telephone interview on 8/20/24 at 3:11 pm LVN AA said that on 2/19/24 just after the evening meal, Resident #3 had thrown up on herself in the dining room. She said she had asked CNA Z to assist her with cleaning the resident up. She said CNA Z did not act like she wanted to, since it was shift change. She said she took Resident #3 to her room and when they pulled down the resident's brief, they realized the resident had also had a bowel movement. She said CNA Z said .are you fucking kidding me? . LVN AA said she was a new nurse at that time and had only been in training at the facility for a few days and really did not know how to handle the situation. She said she sent CNA Z to get her needed supplies to clean the resident. She said CNA Z left room to retrieve supplies when resident began saying that she was getting weak in the knees. She said CNA Z returned to room and they got the resident in the bed. LVN AA said she told CNA Z to leave the room because she continued yelling and cursing at the resident, but she continued standing there yelling at Resident #3 and cursing at her. She said she finally got CNA Z to leave the room and she finished cleaning Resident #3 on her own. She said she had to stay in room for a while with Resident #3 to console her as she was upset. She said she immediately tried to report the incident to the nurse she was training with (LVN C) but LVN C told her .you will have to tell me tomorrow; I have to go .or something to that effect LVN AA said she was finally able to reach the Administrator the next morning and reported the incident. She said she was suspended for not immediately reporting incident to Administrator or DON and was given trainings on how to handle situations in the future. She said she now understood she should have handled the incident differently and immediately reported to administration. She said she no longer works at this facility. During a telephone interview on 8/20/24 at 3:30 pm LVN C said she had been training LVN AA on 2/19/24 and at the end of the shift Resident #3 had vomited in the dining room. She said LVN AA then took resident to her room. She said she heard LVN AA ask CNA Z for help. She said when LVN AA came out of room she did not tell her anything about what happened, and she was unaware of it until the next day. During an observation and interview on 8/20/24 at 3:40 pm Resident #3 was observed in bed wearing a hospital gown. She was alert to person and place. She was unable to appropriately answer questions. She said that her daddy was going to be 67 and he's going to be at the nursing home. 2.Record review of a facility face sheet dated 8/19/24 for Resident #7 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including: metabolic encephalopathy (an alteration in consciousness caused by diffuse or global brain dysfunction from impaired cerebral metabolism), bipolar disorder (a mental health condition that causes extreme mood swings between emotional highs and lows), dementia (a group of symptoms affecting memory, thinking and social abilities), and post-traumatic stress disorder (a disorder that develops in some people who have experienced a shocking, scary, or dangerous event). Record review of a Quarterly MDS assessment dated [DATE] for Resident #7 indicated that he had a BIMS score of 3, which indicated that he had severe cognitive impairment. He had no behaviors indicated on assessment. He required substantial/maximal assistance with toileting and personal hygiene. He was always incontinent of bladder and frequently incontinent of bowel. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a comprehensive care plan dated 2/28/24 for Resident #7 indicated that he was at risk for impaired cognitive function/dementia or impaired thought processes related to Alzheimer's. Interventions included to provide with necessary cues - stop and return if agitated. During an observation and interview on 8/19/24 at 9:00 am Resident #7 was observed in his bed with head of bed elevated eating breakfast. He did not speak much and would only answer yes/no questions. He was asked if staff were all nice to him and he answered yes. He was asked if any staff had ever been mean to him and he answered no. He appeared well-groomed and no odors were noted. During a telephone interview on 8/19/24 at 10:24 am CNA G said on 6/29/24 she and another CNA were changing Resident #7 and he was fighting and becoming aggressive. She said Resident #7's family member alleged that she had tapped his hand like a toddler. CNA G said Resident #7 was slapping her and that she was trying to keep him from hitting her. She said she was suspended for a day or so and had to complete some training classes before she was allowed to return to work. She said she did not work with Resident #7 at any time after incident. During an interview on 8/19/24 at 10:35 am CNA H said on the day of the incident (6/29/24) Resident #7 was wet and she did not want to change him alone due to his behaviors. She said she got CNA G to assist her. She said he was refusing care. She said she was explaining things to him as they went and as she was taking his brief off, he was talking about hitting and kicking them. She said at one point he grabbed CNA G's arm with both of his hands and started squeezing her with both of his hands and he kept squeezing her arm. She said CNA G tried to get him to let go and she lightly tapped him on the hand. She said after they finished his care, they reported his behaviors to the charge nurse. She said she had been trained on dealing with aggressive behaviors and they are supposed to leave the resident in a safe position and return later to try again. During an interview on 8/20/24 at 9:00 am the DON said on 6/29/24 Resident #7's family member had come in and said she had seen on the camera when CNA G and CNA H were in room that CNA G had tapped his hand like a baby. She said she started an investigation and watched the video many times and both CNAs were suspended. She said she reported the incident to state, spoke to both employees, did in-services and trainings. She said CNA G was no longer allowed to work with Resident #7 after incident. She said there had been no prior incidents with CNA G and none after. She said CNA G had been a very good aide. She said she does train her staff to walk away and notify a nurse if a resident is combative or refusing care. During an observation on 8/20/24 at 11:15 am a video sent from Resident #7's family member was observed in which CNA H and GNA G were observed providing incontinent care to Resident #7. CNA G was explaining to Resident #7 they were trying to help him and change his brief. She told him multiple times not to hit her. CNA H was then observed on residents left hand side of bed and had his left hand/arm with her hands, while CNA G was observed on residents' right-hand side of bed and had his right hand/arm in her hands. CNA G again told Resident #7 not to hit her. Resident #7 was then observed raising left hand/arm. At this point, Resident #7 said I'll break your Goddamn arm; CNA G appeared to tap Resident #7 on the right hand; an audible sound could be heard which sounded like a slap, then video stopped. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/20/22 at 11:38 am Family Member of Resident #7 said that he had returned to facility on 6/27/24 after a stay at a behavioral facility. They said they notified the facility on 6/29/24 of the incident on video. They said Resident #7 did have some behavioral issues, but he still deserved to be treated appropriately. During an interview on 8/21/24 at 3:15 pm the DON said that she and the Administrator are both responsible for training staff on dignity and resident rights and ensuring residents are treated with dignity and respect. She said she terminated CNA Z as soon as she was made aware of the incident. She said she and the Administrator were unable to determine if CNA G had tapped Resident #7's hand or not. She was suspended, received in-services and trainings, and was allowed to return to work. She did not work long after the incident and no longer works at the facility. She said going forward, they would continue to do orientations, trainings and in-services on resident rights and dignity. She said residents could be at risk of feeling intimidated and threatened if staff treated them without dignity and respect. During an interview on 8/21/24 at 3:39 pm Administrator said they would be providing additional trainings on resident rights and dignity. She said residents could be at risk of being scared, intimidated, and not calling for help when needed if they were not treated with dignity and respect. Facility took the following actions to correct the noncompliance on 6/29/24: Record review of a termination form dated 2/20/24 for CNA Z indicated that her last day worked was 2/20/24 and termination date was 2/20/24. Form indicated that this was an involuntary termination due to Code of Conduct Violation, Gross Misconduct, and Poor Job Performance and was signed by DON, Administrator and HR on 2/20/24. Record review of a facility in-service form dated 2/20/24 titled Abuse/Neglect; Elder Justice Act; Trauma; Alzheimer's/Dementia indicated that all staff were in-serviced on these topics on 2/20/24. Record review of personnel files for CNA H and CNA G indicated that they both received an in-service on Abuse and Neglect which included Recognizing, Reporting and Preventing Abuse, Managing Challenging Behaviors in Dementia, Dementia Care and Behavioral Challenges, Physical Abuse, Abuse and Neglect, and Trauma Informed Care on 6/29/24. Record review of a facility in-service indicated all staff were in-serviced on Abuse and Neglect which included Recognizing, Reporting and Preventing Abuse, Managing Challenging Behaviors in Dementia, Dementia Care and Behavioral Challenges, Physical Abuse, Abuse and Neglect, and Trauma Informed Care on 6/29/24. Record review of a facility policy titled Resident Rights - Dignity and Respect revised 8/2021 read .It is the policy of this facility that all residents be treated with kindness, dignity and respect . and .The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment that did not result in bodily injury within 24 hours for 1 of 17 residents (Resident #1) reviewed for abuse and neglect. The Administrator failed to report an allegation of neglect on 11/7/2023 when Resident #1 eloped from the secured unit out of his window, into the courtyard and broke out of the wooden fence. This failure could place residents at risk for harm and injury. Findings included: Record review of an Admission Record dated 8/19/2024 for Resident #1 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, depression, and anxiety disorder. Record review of a Quarterly MDS assessment dated [DATE] for Resident #1 indicated he had moderate impairment in thinking with a BIMS score of 9. He had potential indicators of psychosis with delusions (misconceptions or beliefs that are firmly held, contrary to reality). Record review of a care plan dated 9/19/2023 for Resident #1 indicated he had secure unit placement and was an elopement risk/wanderer related to dementia. History of dangerous walking, elopement attempts. Interventions included to document wandering behavior and attempted diversional interventions. Record review of a nurse progress note for Resident #1 dated 11/7/2023 at 2:30 PM by ADON D indicated, Spoke with desk at Dr. office at this time, updated on incident which occurred on today regarding elopement attempts. Stated she would forward the message to Dr and his nurse with priority for response. Awaiting return call at this time. Record review of an Incident Report for Resident #1 dated 11/7/2023 at 2:30 PM by ADON E indicated, Pt. noted not inside of room. Staff noted window unlocked and Pt. was not inside of unit. Staff went outside and noted Pt. behind storage building on outskirts of courtyard, during head-to-toe assessment/skin assessment. Pt noted with 0.5 cm x 0.5 cm S/T to right arm, scattered/multiple scratches to bilat upper and lower extremities. Resident description: Pt. states I just wanted to go outside so I unlocked my window and crawled out, I'm not hurt, it's just some little scratches. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 11:26 AM, ADON E said she was responsible for the incident/accidents, changes in condition and 24-hour reports. She said Resident #1 was admitted to the secured unit when he arrived at the facility. She said on 11/7/2023, Resident #1 was in the secured unit when he broke out of his window in his room into the courtyard and got out of the fence. She said when he was found he had scratches on his arms and a skin tear. She said they found him back by some trees at the back of the facility behind the secured unit. She said he was immediately assessed; his family member was at the facility to visit but was not sure if the family member was present at the time of the elopement. She said he was found not far away from the facility and did not think the incident was a reportable event because he was still on the grounds. She said Resident #1 left the facility without staff knowing and was not sure if he had done that before. She said it was not left up to her to make the decision if the incident was reportable or not. She said the abuse coordinator who was the Administrator, and the DON would make that decision. During an interview on 8/19/2024 at 12:11 PM, the DON said Resident #1's family member was at the facility at the time of the incident on 11/7/2023. She said the family member of Resident #1 told the aides that he was in the bathroom and would not come out. She said that was when they discovered he was not in the room and said she was not gone for no more than 5 minutes. She said the staff in the secured unit had just seen Resident #1 in his room. She said Resident #1 broke out of the window in his room and kicked the door down in the courtyard. She said following the incident, the Maintenance Supervisor placed a bigger latch on the courtyard door. She said since he was not gone anytime, she did not report it. She said she investigated the incident, talked to staff, and said the staff told her they had just seen him prior to the incident. She said she in-serviced the staff on elopement. During a follow up interview on 8/19/2024 at 2:42 PM, the DON was questioned about how they determine when an incident should be reported to the state agency. She said it depended on the situation. She said she did a lot of the reporting to the state agency when she was on call, but they were mostly done by the Administrator. She said they followed their policies and incidents were situational. She said she could not give any specifics regarding incidents being situational. She said they did reach out to their Resource Leader who helped the facility with making decisions about reporting incidents. She said she did not consider a resident missing if they did not leave the premises and Resident #1 did not leave the premises. During an interview on 8/19/2024 at 2:52 PM, the Administrator said she was the abuse coordinator for the facility. She said she was notified on the day Resident #1 eloped from the facility on 11/7/2023. She said he had gotten out of the gate of the secured unit, exited the window and went through the gate. She said he was found next to a tree outside of the facility. She said the incident was not reported because he did not leave the premises. She said on admission to the facility, Resident #1 was confused but at the time of the incident on 11/7/2023 his thinking had improved. She said regarding reporting if someone was missing or not, the time frame would have to be about 10 minutes or so of not being aware of them missing. She said she did not think the incident needed to be reported. She said she did not consider him a missing resident. She said she and the DON on occasions reach out to their Resource Leader and they would let them know if the incident was reportable or not. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 3:14 PM, the Resource Leader said the facility did not contact her on a regular basis about any issues because she visited the facility about once a week. She said she spoke to the DON and another Resource Leader about the incident on 11/7/2023 with Resident #1 and they looked at the PL 19-17 for guidance. She said Resident #1 did not leave the premises and according to their elopement policy, if a resident does not leave the premises, then they are considered missing, so the incident was not reported to the state agency. Record review of a facility policy titled Elopement/Unsafe Wandering revised 12/2023 indicated, .If is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. Elopement occurs when a resident leaves the facility premises without the facility's knowledge, authorization (i.e., an order for discharge, appointment, or leave of absence) and/or any necessary supervision to do so. 10. The facility will notify the appropriate State Agency in accordance with state requirements. 11. Notification to the appropriate State Agency will be made: a. Within twenty-four (24) hours of the serious accident/incident . Record review of a Long Term Care Regulatory Provider Letter titled Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Facility (NF) Must Report to the Health and Human Services Commission (HHSC) dated July 10, 2019 indicated, .2.1 Incident that a NF Must Report to HHSC and the Time Frames for Reporting: A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: a missing resident. An incident that does not result in serious bodily injury and involves: a missing resident-Immediately, but not later than 24 hours after the incident occurs or is suspected . Record review of a facility policy titled Resident Rights-Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment revised 11/28/2017 indicated, .It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origin and misappropriation of resident property, are reported immediately but: Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: The State Survey Agency .

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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** 43994 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for 2 of 3 residents (Resident #1 and Resident #4) reviewed for accidents. The facility failed to keep Resident #1 in a safe environment to prevent an elopement on 11/7/2023 when he climbed out of a window in the secured unit and broke a fence in the courtyard. The facility failed to keep Resident #4 in a safe environment to prevent an elopement on 11/20/2023. The noncompliance was identified as PNC (past non-compliance). The IJ (immediate jeopardy) began on 11/7/2023 and ended 11/20/2023. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for serious injury and accidents. Findings included: 1.Record review of an Elopement/Wandering Evaluation by ADON D dated 7/14/2023 for Resident #1 indicated he admitted to the facility on [DATE]. He had dementia, ambulated with an assisted device, was disoriented, and had a history of 2 or more episodes of elopement in the last 6 months. He was indicated as a high risk for elopement with a score of 16. Score ranges: low risk 0-9 and high risk 10-55. Record review of an Admission Record dated 8/19/2024 for Resident #1 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of dementia, depression, and anxiety disorder. Record review of a care plan dated 9/19/2023 for Resident #1 indicated he had secure unit placement and was an elopement risk/wanderer related to dementia. History of dangerous walking, elopement attempts. Interventions included to document wandering behavior and attempted diversional interventions. Record review of an Elopement/Wandering Evaluation by ADON D dated 10/11/2023 for Resident #1 indicated he admitted to the facility on [DATE]. He had dementia and ambulated independently or with supervision. He had intermittent confusion, made statements about a desire to leave the facility and wandered aimless with the potential to go outside with active exit seeking behavior. He was indicated as a high risk for elopement with a score of 15. Score ranges: low risk 0-9 and high risk 10-55. Record review of a Quarterly MDS assessment dated [DATE] for Resident #1 indicated he had moderate impairment in thinking with a BIMS score of 9. He had potential indicators of psychosis with delusions (misconceptions or beliefs that are firmly held, contrary to reality). (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 a nurse progress note for Resident #1 dated 11/7/2023 at 2:30 PM by ADON D indicated, Spoke with desk at Dr. office at this time, updated on incident which occurred on today regarding elopement attempts. Stated she would forward the message to Dr and his nurse with priority for response. Awaiting return call at this time. Record review of an Incident Report titled Skin Alteration for Resident #1 dated 11/7/2023 at 2:30 PM by ADON E indicated, Pt. noted not inside of room. Staff noted window unlocked and Pt. was not inside of unit. Staff went outside and noted Pt. behind storage building on outskirts of courtyard, during head-to-toe assessment/skin assessment. Pt noted with 0.5 cm x 0.5 cm S/T to right arm, scattered/multiple scratches to bilat upper and lower extremities. Resident description: Pt. states I just wanted to go outside so I unlocked my window and crawled out, I'm not hurt, it's just some little scratches. Record review of a witness statement dated 11/7/2023 by LVN C indicated, Resident #1 was in hallway upset, because he wanted to go home and requesting a phone. He stated that's ok, I'll find one. Resident then proceeded to his room and closed the door as he always does. I then preceded to contact his family member and update her on his request to go home. She stated, I'm gonna go ahead and get my husband and we'll be up there to let him know he'll be staying there permanently. I was in unit talking to staff about medications. Resident family and her husband arrived about 15-20 minutes later. She stopped to speak with me, then went into resident room. A few minutes later the daughter came out and said he's in the bathroom, I've been knocking and waiting but he won't come out. I immediately went in and knocked on the door, no response. I opened the door and resident was not inside. I went to the window and noticed the back gate was open. I then alerted admin and staff to search for resident. Record review of a Q 15-minute observation form for Resident #1 indicated q15 minute monitoring started at the facility on 11/7/2023 at 2:45 PM and ended on 11/8/2023 at 2:30 PM. Record review of an elopement/wandering evaluation post incident on 11/7/2023-11/10/2023 did not reveal any evaluations were conducted. 2. Record review of a facility face sheet dated 8/19/24 for Resident #4 indicated that she was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: Alzheimer's and hypertension. Record review of a Quarterly MDS assessment dated [DATE] for Resident #4 indicated that she had a BIMS score of 3, which indicated that she had severe cognitive impairment. She had no wandering behaviors during assessment period. She used a wheelchair for mobility and was dependent with most ADLs. Record review of a comprehensive care plan dated 11/20/23 for Resident #4 indicated that she was an elopement risk/wanderer related to history of attempts to leave facility unattended and she wandered aimlessly. Focus included secure unit placement on 11/20/24. Record review of a facility form titled Elopement/Wandering Evaluation dated 9/6/23 for Resident #4 indicated that she was mobile in wheelchair, had intermittent confusion, no history of elopement, and was a low risk for elopement. (continued on next page)

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	675962	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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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 a facility incident report dated 11/20/23 for Resident #4 indicated that she propelled self out of facility. During an observation on 8/19/24 at 9:18 am Resident #4 was observed sitting up in wheelchair in common area of secured unit. She was confused and did not answer questions. During an observation on 8/19/2024 at 9:34 AM, in the secured unit by the dining room exit had a keypad, exit leads out into a wooden fenced in area in a courtyard. There was a wooden fence that was about 8 feet tall that had double doors that was secured by a metal latch and pad locked. During an observation and interview on 8/19/2024 at 9:38 AM, CNA B said she had been employed at the facility for 9 years and work 6a-6p and always worked in the secured unit. She said about 65% of the residents in the unit wander and some like to go up and down the halls and will go in other rooms rummaging through other resident's things. She said there were a couple of them that tried to exit seek with holding down the exit door and would get out in the courtyard that was fenced in. She said she remembered when Resident #1 was in the secured unit and there was an incident when he used silverware and popped the screen off his window and the screw or nail came out. She showed the Surveyor the room where he resided and the window in the room had 2 screws on frame of the window above the top of the window on the left and right side that were screwed into the frame. She said on that day a family member had stopped by to visit him. She said Resident #1 kicked the gate open in the courtyard and it had a pad lock. She said that day she was not on the clock but was at the facility visiting a friend who worked that day. She said they found Resident #1 not long after it was discovered that he was not in his room. She said if there was not a fence dividing the property, then there could have been a chance for it to have taken longer to find him. She said no one heard him go out of his window or break the fence. She said he was not outside for a long time. She said they brought him back in and he was winded but looked fine. She said they did provide 1:1 supervision with him after the incident and he was informed that he could not leave. She said shortly after the incident he discharged and did not return. She said following the incident they had in-services on elopement. She said if they noticed a resident was missing, they were to report to the nurse and check everywhere. She said she just tells the nurse, and they take over from there. Attempted a phone interview with LVN C on 8/19/2024 at 11:00 AM, left a message for a return phone call. During an interview on 8/19/2024 at 11:06 AM, ADON D, said Resident #1 resided on the secured unit when he was at the facility. She said she called the physician about Resident #1 having an elopement at the facility. She said on 11/7/2023, Resident #1 unscrewed the window in his room, as there was a screw that kept the window from opening all the way. She said he took a butter knife and opened the window and got out into the courtyard in the secured unit. She said he did go out of the gate, but never left the premises. She said the physician called her back on the 11/8/2023 and gave an order for Rexulti 2 mg daily and then recommended behavioral hospital and started working on that and he discharged to a behavioral hospital sometime after the incident. She said he was on the secured unit for wandering purposes, he was on q15 minutes checks. The other ADON was the one responsible for handling incident/accidents for the resident. She said an aide noticed him and would not tell the surveyor anything else. Said she needed to get someone else because she could not answer those questions. (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 8/19/2024 at 11:26 AM, ADON E said she was responsible for the incident/accidents, changes in condition and 24-hour reports. She said Resident #1 was admitted to the secured unit when he arrived at the facility. She said on 11/7/2023, Resident #1 was in the secured unit when he broke out of his window in his room into the courtyard and got out of the fence. She said when he was found he had scratches on his arms and a skin tear. She said they found him back by some trees at the back of the facility behind the secured unit. She said he was immediately assessed; his family member was at the facility to visit but was not sure if the family member was present at the time of the elopement. She said he was found not far away from the facility and did not think the incident was a reportable event because he was still on the grounds. She said Resident #1 left the facility without staff knowing and was not sure if he had done that before. She said it was not left up to her to make the decision if the incident was reportable or not. She said the abuse coordinator who was the Administrator, and the DON would make that decision. During an observation and interview on 8/19/2024 at 11:38 AM, ADON E conducted a walk through the secured unit on how Resident #1 was able to exit the unit. She walked with the Surveyor from the room where Resident #1 resided in the secured unit into the courtyard and showed how he broke through the wooden fence and was found in the wooded area by the facility approximately 30 feet from the wooden fence. She said he was found leaning up against a tree still on the property, not in the woods. There were 4 brown portable buildings noted and 2 trash cans by the building where she said he was found. She said when they found him, they took him and sat him on the bench that was outside at the end of A hall because he was winded, and his daughter was present at that time. She said the facility did have cameras at the facility but had recently upgraded their system and was not sure if they still had video footage of the incident with Resident #1. During an interview and observation on 8/19/24 at 11:40 am ADON E said that Resident #4 was found near the dumpsters at end of C-hall. She said she can't remember who brought her back in, that it was on the night shift. Dumpsters observed near several portable buildings and wooded area with chain link fence. During an interview on 8/19/2024 at 11:49 AM, the Maintenance Supervisor said Resident #1 resided in the secured unit in room [ROOM NUMBER]. He said the windows in the secured unit had lag bolts on both sides of the windows. He said he found the bolt and a butter knife in Resident #1's drawer in the room following the incident. He said Resident #1 was able to tell him that he used it to get out of the window on 11/7/2023. He said Resident #1 broke the back double gate in the courtyard of the secure unit and it previously had a smaller hook and clasp, and it broke. He said the door on the fence with a larger clasp and a bigger bolt with a pad lock. He said he also secured the door on the fence with stronger lag bolts and wood to secure it. He said he conducted an elopement drill with staff on day and night shifts following the incident and made sure all the lag bolts on the windows were secured and replaced and put in a different place on Resident #1's window. He said he made sure all the windows had devices in place in the secure unit. (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 8/19/2024 at 12:11 PM, the DON said Resident #1's family member was at the facility at the time of the incident on 11/7/2023. She said the family member of Resident #1 told the aides that he was in the bathroom and would not come out. She said that was when they discovered he was not in the room and said she was not gone for no more than 5 minutes. She said the staff in the secured unit had just seen Resident #1 in his room. She said Resident #1 broke out of the window in his room and kicked the door down in the courtyard. She said following the incident, the Maintenance Supervisor placed a bigger latch on the courtyard door. She said since he was not gone anytime, she did not report it. She said she investigated the incident, talked to staff, and said the staff told her they had just seen him prior to the incident. She said she in-serviced the staff on elopement. During an interview on 8/19/24 at 12:15 pm DON said the staff heard the alarm go off when Resident #4 went out the end B-hall door. She said staff were all in rooms and when they heard the alarm go off, they looked out of the rooms into the hallways. She said they were doing a foley catheter on someone on F-hall and they didn't see anyone. She said they did not do a room check. She said resident was outside a long time and that it was reported to state agency as an elopement. During an interview on 8/19/24 at 12:25 pm Maintenance Sup said he was not here when Resident #4 eloped and did not remember exactly where she was found. He said he did elopement drills afterwards and checked the egress doors. During an interview on 8/19/24 at 1:42 pm DON said that the garbage man found Resident #4 while he was here to pick up the trash from the dumpsters. She said she watched the video showing Resident #4 eloping from the egress door on the end of B-hall. She said she could not remember exactly how long she had been outside but said possibly 15 to 20 minutes maybe. Said that staff did not do a head count after they heard the alarm going off, said they did look outside but it was dark, and they did not see anything. During a telephone interview on 8/19/24 at 2:18 pm Director of city disposal services was questioned on which driver would have picked up trash that night and he took surveyors name and telephone number. He said he would call back with further information if he found out anything. During a telephone interview on 8/19/24 at 2:18 pm Director of city disposal services returned phone call and said that he had spoken to his driver that picked up the trash at facility. He said the driver did not recall any incident of finding a resident outside and bringing her back. During a follow up interview on 8/19/2024 at 2:42 PM, the DON was questioned about how they determine when an incident should be reported to the state agency. She said it depended on the situation. She said she did a lot of the reporting to the state agency when she was on call, but they were mostly done by the Administrator. She said they followed their policies and incidents were situational. She said she could not give any specifics regarding incidents being situational. She said they did reach out to their Resource Leader who helped the facility with making decisions about reporting incidents. She said she did not consider a resident missing if they did not leave the premises and Resident #1 did not leave the premises. She said she in-serviced the staff and started a soft file on the incident but did not report it. (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 8/19/2024 at 2:52 PM, the Administrator said she was the abuse coordinator for the facility. She said she was notified on the day Resident #1 eloped from the facility on 11/7/2023. She said he had gotten out of the gate of the secured unit, exited the window and went through the gate. She said he was found next to a tree outside of the facility. She said the incident was not reported because he did not leave the premises. She said on admission to the facility, Resident #1 was confused but at the time of the incident on 11/7/2023 his thinking had improved. She said regarding reporting if someone was missing or not, the time frame would have to be about 10 minutes or so of not being aware of them missing. She said she did not think the incident needed to be reported. She said she did not consider him a missing resident. She said she and the DON on occasions reach out to their Resource Leader and they would let them know if the incident was reportable or not. During an interview on 8/19/2024 at 3:14 PM, the Resource Leader said the facility did not contact her on a regular basis about any issues because she visited the facility about once a week. She said she spoke to the DON and another Resource Leader about the incident on 11/7/2023 with Resident #1 and they looked at the PL 19-17 for guidance. She said Resident #1 did not leave the premises and according to their elopement policy, if a resident does not leave the premises, then they are considered missing, so the incident was not reported to the state agency. During a telephone interview on 8/19/24 at 4:07 pm CNA AB said she was in a room with a resident when she said she heard the alarms going off. She said she notified the nurse and went outside to look for resident but did not find her. She said that they checked the rooms and by then, someone was ringing the doorbell with Resident #4. During a telephone interview on 8/19/24 at 4:20 pm CNA AC said she was in another room on F hall helping the nurse do a catheter on a resident. She said she never heard the alarms going off when Resident #4 opened the egress door. She said after she came out of the room, they heard the alarm going off, but they thought it was the fire alarm. She said they checked rooms, but did not notice that Resident #4 was missing, and they assumed she was in the bathroom. She said someone came to empty the trash and found her, then brought her back to the front. She said she was new at the time and did not know what the fire alarm sounded like. She said shortly after the incident they had an in-service on alarms to distinguish the difference. During a telephone interview on 8/20/24 at 8:18 am LVN A said that she, another nurse and 2 CNAs were in a resident room doing a catheter for a urine sample. She said she thought the other 2 aides in the facility were making rounds. She said she did not hear the door alarm going off at all while she was in the room, but when she came out of the room, the doorbell was ringing. She said after resident was brought back in, they assessed her, did vitals, and the other nurse did notifications of on-call nurse. The on-call nurse then notified the DON. She said she did not remember doing any in-services after the incident. She said after Resident #4 was back in facility and all notifications were made, they then did a head count to ensure there were no other missing residents. Record review of a facility policy titled Secured unit Admission Criteria dated 9/2023 indicated, .Admission to the Secured Unit is based on diagnostic, functional and behavioral criteria that determine that the resident can benefit from this special environment. Once a resident is accepted for admission to the unit, assessment of the resident's status and appropriateness for the unit is ongoing (at least quarterly and PRN for changes in condition) . (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 a facility policy titled Elopement/Unsafe Wandering revised 12/2023 indicated, .If is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. Elopement occurs when a resident leaves the facility premises without the facility's knowledge, authorization (i.e., an order for discharge, appointment, or leave of absence) and/or any necessary supervision to do so. 6. Complete an Elopement/Wandering Evaluation of the resident post elopement incident with continued follow up documentation for a minimum of 72 hours following the incident . The facility took the following action to correct the non-compliance on 11/20/2023: Record review of emergency preparedness drill: missing person/elopement was conducted on 11/7/2023 at 10:15 AM by the Treatment Nurse. Record review of emergency preparedness drill: missing person/elopement was conducted on 11/7/2023 at 8:00 PM by the LVN AD. Record review of a Q 15-minute monitoring for Resident #1 was started on 11/7/2023 at 2:45 PM and ended on 11/8/2023 at 2:30 PM. Record review of an In-service training report dated 11/20/23 indicated that all staff were in-serviced on fire drills on 11/20/23. Record review of facility form titled Emergency Preparedness DRILL: Missing Person/Elopement dated 11/20/23 indicated that staff on all shifts received an elopement drill on 11/20/23. Record review of an in-service training report dated 11/20/23 indicated that all staff were in-serviced on Elopement drills, trauma, sensitivity, Alzheimer's Dementia, and elopement/unsafe wandering guidelines on 11/20/23. Record review of a physician's order dated 11/20/23 for Resident #4 read .May admit to secured unit . Record review of a facility form titled Weekly Preventative Maintenance Task Sheet - Door Security Systems dated 11/20/23 indicated that all egress doors had been checked and were functioning and that affected personnel in area had been trained on 11/20/23. Interviews on 8/21/2024 from 9:27 AM to 12:00 PM included: (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 8/21/2024 at 9:27 am, the DM said she had a training drill on elopement early this morning in the facility and had in-services on elopement/missing residents this past week. She was able to verbalize the silver dots on the doors indicated that a resident was a high risk for elopement, could also look in the elopement binder and the Kardex. She said dietary did not have access to the Kardex. She said she took a test on wandering on their online training program and had one that was written when they did in-service over true/false questions. She said if you received a notification that a resident was missing, then you did a head count, checked closets, bathrooms, go outside and around building and if resident cannot be found, call the DON. She said you must check to see if they are out on pass, if not, call the emergency contact, physician, and law enforcement. During an interview on 8/21/2024 at 9:30 am, the [NAME] verbalized trainings on elopement/missing residents was held this past week. She said if a resident came up missing, if a light goes off, they have probably gone out of the door. She said they are to immediately stop what you they were doing, try to locate the resident and conduct a head count. She said she was trained on where to find the elopement binder, to look in the book to see if the resident was out on pass, and to call and see if they are out on pass. She said they would also conduct a head count. She said the silver stars on doors and the elopement book would let them know which residents were high risk for elopement. She said she took a test on the computer and did a paper test over elopement. During an interview on 8/21/2024 at 9:36 am, the DA said he received training on elopement/missing residents this past week. He said he was trained on the silver dots are for residents that are high risk. He said if a resident was missing then they would look for the lights on the hall, go outside to try to find the resident, and if unable to locate, then would notify the nurse. He said he took a test online and a true/false test on paper. During an interview on 8/21/2024 at 9:38 am, the Dishwasher said he had trainings this past week on elopement/missing residents. He said he had training on the computer regarding if someone came up missing, on the door alarms, and steps to take on when they are or not found. He said if a resident was missing, find out which hall the alarm was going off on and go out there and look for the resident, notify the nurse, and conduct a head count. He said he would look behind the buildings, by dumpsters, and in wooded areas to try and find residents. He said residents that were high risk in the facility had a silver dot on their doors, listed in the binder by nurses' desk, and was in the Kardex. He said he took a test on what to do when the alarm goes off and a test on paper. During an interview on 8/21/2024 at 9:45 AM, the BOM said she received training this past week on elopements on their online training program, had active drills for elopements, and was in-serviced as a group over elopements. She said if a resident was missing, they would call a code silver, start search, notify the nurse, the Administrator and DON. She said she was part of the calvary that was called in to help search and they would also call the police but would immediately start searching. She said she was taught in elopement training that if an alarm goes off, a light above the hall that the alarm was from, go outside and physically search for them while other employees look inside the facility. She said they would then conduct a head count, call the police, notify the DON, Administrator, and other department heads. She said residents that were high risk for elopement had silver dots outside their door, there was a book at nurses' station with their information in it and they could look at the Kardex in the computer charting system. She said she took a test online and a paper test with the in-service. (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 9:48 am, Admissions said she was trained on how to identify elopement risks, and there were silver dots on the name plates of the residents that were high risk and could find the information in the Kardex in the charting system. She said there was a binder that also had the information. She said if an alarm went off, employees would split up and start searching, and do a head count. She said they had elopement drills, took a test on paper and online. During an interview on 8/21/2024 at 9:50 am, the ABOM said this past week she had trainings over elopement and wandering risks. She said they had an elopement drill and completed videos online on elopement, and took a test on elopement, and had in-service trainings. She said a resident that was high risk for elopement would have a silver dot outside of their room on their doors, they would also be in the elopement risk binder, and in the Kardex. She said if a resident was missing, would notify the Administrator, Don, MD on call, law enforcement the family. She said they would immediately search for the resident outside of the facility, do head count, and search facility wide. She said they would check the binder to see if family had taken them out on pass, if not, would keep searching and get everyone involved. She said she took a written test and online training with a test on elopement. During an interview on 8/21/2024 at 9:54 AM, the Receptionist said this past week she had trainings on elopement/missing residents. She said they had drills for when the lights flash to see if a resident had gotten out and to check all areas inside and out. She said she had training and testing on the computer and an in-service on elopement. She said the silver stars or dots on door nameplate, a binder with info, and the Kardex (she does not have access) would help to identify what residents were at risk for elopement. She said she took tests online and one on paper. During an interview on 9:56 am, the Transportation Driver said she had trainings over elopement this past week. She said there were alarms on each door, and it would identify which hall and go out that hall door and look. She said if you do not see anyone, notify the nurse and she would call a code silver. She said the nurse would then assign everyone somewhere to search and conduct a head count, identify who was missing and if not located, notify the DON, Administrator, and the police. She said residents who were high risk for elopements could be found in the Kardex, a binder, and there were silver dots on their doors. She said she had tests on paper and one online. During an interview on 8/21/2024 at 10:00 am, PTA said she had elopement training this week. She said the training included on knowing what to do, what the alarm sounded like, fastest way to identify a missing patient, identify which hall alarm was coming from, go outside and look, if you don't see anyone, notify nurse, code silver, check all rooms, closets, bathrooms, do head count. Look to see if they are on pass. She said there was an elopement binder at nurses' station that had residents who were high risk for elopement, could also find the information in the Kardex in the charting system and their rooms would have a silver dot by their names. She said she did a test on paper and online over elopement. During an interview on 8/21/2024 at 10:03 am, the OTA/ADOR said he was trained on elopement this week and how to identify a resident who was at risk along with the steps to take. He said the elopement binder, Kardex and a silver dot on the name plates indicate who are high risk for elopement. He said if a resident was missing, would identify door light, report to the charge nurse, check the immediate area outside, call code silver, and do a head count. He was tested on elopement online and paper. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675962	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southland Rehabilitation and Healthcare Center	501 N Medford Dr Lufkin, TX 75901

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	During an interview on 8/21/2024 at 10:05 am, PT said he was trained on identifying elopement risks for residents and procedures. He said if a resident was a high risk for elopement could find that information in the Kardex, in the care plan, the elopement binder at nurses' station, or a silver dot on the resident's door. He said if a resident was missing resident an alarm would go off, would go down to the end of the hallway and report to the charge nurse. He said he would go outside and search for the resident, conduct an internal search, and conduct a head count of the residents. He said then they would notify the DON, Administrator, RP, and the police. He said he was tested on procedures on paper and online. During an interview on 8/21/2024 at 10:07 am, OT said he had been trained and had in-services on elopements and identifying if someone had left the facility. He said they were told to look for the lights, sounds, and see where they were coming from. He said they would look for them, do a head count, and notify the DON and the Administrator. He said if a resident was high risk for elopement they would have a silver sticker on their doors, could find the information in the Kardex and in the elopement binder. He said he was tested on paper and online. During an interview on 8/21/2024 at 10:10 am, COTA said she had elopement trainings and some on the computer. She said they were taught on the procedure to take which included if an alarm sounded, look at the end of each hall to identify the hall where the resident was, look outside to see if you can see them, and if not notify the nurse for a code silver. She said the silver dots on the doors, the elopement binder and the Kardex would indicate