STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676042	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Transitional Care Center	2109 South K St MC Allen, TX 78503

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** 47573 Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 6 residents (R #6) reviewed for supervision. The facility failed to ensure R #6 received adequate supervision as R #6 eloped from the facility without anyone's knowledge on 07/08/24 at around 3:16 AM and went to a corner store approximately 0.5 miles away. R #6 experienced a change of condition (UTI), had increased confusion, and was unsupervised for approximately 1 hour and 15 minutes before the facility became aware that he had eloped. An Immediate Jeopardy was identified on 07/08/24. The Immediate Jeopardy template was provided to the facility Administrator on 07/30/24 at 11:20 AM. While the Immediate Jeopardy was removed on 07/31/24 at 10:30 AM, the facility remained out of compliance pending approval of Plan of Correction. This failure could lead to residents exiting the facility unattended which could result in injuries, hospitalization , or death. The findings included: Record review of R #6's face sheet dated 06/10/24 reflected an [AGE] year-old male, with an original admitted [DATE]. Diagnoses included: unspecified dementia, chronic obstructive pulmonary disease (progressive lung disease that results in breathlessness and cough), depression, anxiety disorder, insomnia, and osteoarthritis (arthritis that affects any joint, causes pain, stiffness, and loss of mobility). Record review of R #6's MDS assessment dated [DATE] reflected R #6 had a BIMS score of 11 (moderate cognitive impairment), required setup or clean-up assistance (helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity) with sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, and toilet transfer. R #6 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for walking 10 feet. The MDS also reflected R #6 used a wheelchair. Record review of R #6's Care Plan dated 07/10/24 reflected the following care areas: (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	*R #6 had a UTI. Interventions included to monitor/document/report to MD for signs/symptoms of UTI: Frequency, Urgency, Malaise (ill, fatigued), foul smelling urine, dysuria (painful urination), fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria (blood in urine), cloudy urine, altered mental status, loss of appetite, behavioral changes. Date initiated: 07/05/24. *R #6 reflected an elopement: at risk for delirium or an acute confused episode related to UTI, change in condition. At risk for elopement related to disoriented to place. On 07/08/24, R #6 was found outside facility grounds. R #6 was placed on 30-minute checks. Hospice would visit R #6 more frequently. Family wish to transition to standard wheelchair and not use the power wheelchair for now. Pharmacy to evaluated medications. Date initiated: 07/08/24. Record review of R #6's elopement assessment dated [DATE] reflected score of 3, low risk. Record review of R #6's BIMS assessment dated [DATE] reflected BIMS score of 3, severely cognitively impaired. Record review of R #6's elopement assessment dated [DATE] reflected score of 15, high risk. Record review of R#6's BIMS assessment dated [DATE] reflected BIMS score of 11, moderately cognitively impaired. Record Review of R #6's progress notes for July 2024 reflected the following: - 07/08/24 at 5:00 AM, documented by LVN A indicated the facility received call from LE stating R #6 was at a local corner store and left building without informing staff. LVN A assisted in bringing R #6 back into building. R #6 had motorized wheelchair and was very mobile with it. Last noted in room at 3:30 AM. At this time, R #6 appeared to be in stable condition, some confusion noted, more than baseline. R #6 was able to tell LVN A his name and location but did not recall date or time. Head to toe assessment completed and all within normal limits. Vitals signs were stable, and skin was intact. Per R #6, he wanted to smoke but needed a lighter and decided to go to store to buy one. R #6 stated that he forgot what way to come back so he asked the store clerk to call for directions. The RP, DON, Administrator and MD called to inform of elopement. At this time, R #6 was safe in the room. LVN A assigned 1:1 staff with R #6 until further directions from DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 07/08/24 at 7:15 AM, documented by the DON indicated R #6 was noted outside facility grounds this morning. Assessment followed up by this RN. R #6 was currently in bed, awake/alert confused, with RP at bedside. As per R #6, stated he felt the urge to smoke but did not have a lighter and decided to leave facility with his power wheelchair to the corner store without advising staff. Once R #6 arrived at the store, he stated he did not take his money and asked for directions back to facility which at that time the store clerk assisted him by calling local LE. LE then called the facility to inform of R #6's whereabouts and he was safely transferred to facility with assistance of LVN A and RNA B. Head to toe assessment conducted by LVN A and followed up by this RN at this time. The assessment was within normal limits, vital signs were within normal limits. As per the RP, who was at bedside, she stated she believed his acute confusion was noted by her yesterday morning and thought his UTI was not resolved. R #6 was currently on antibiotics for a UTI and was started on a patch for pain by hospice. The RP wished to discontinue the patch for now as his pain was better controlled by Morphine. The DON spoke with the hospice nurse who would stop by today to assess R #6. The Medical Director was made aware of the occurrence. He advised to consult with psych for re-evaluation and do a urine analysis (UA) for UTI follow up. The RP was aware and agreed with the recommendation. - 07/08/24 at 10:40 AM, documented by the DON indicated the hospice nurse was at bedside and assessed R #6. Discussion occurred about R #6 leaving facility without notifying staff this morning. The hospice nurse talked to R #6 and education was provided about leaving the facility which R #6 verbalized understanding. Plan was to discontinue the pain patch per family request. The hospice nurse agreed with the UA and psych evaluation per the Medical Director recommendation. At this time R #6 was frequently monitored by the licensed nurse every 30 minutes, visual checks for the next 72 hours. All doors in the facility were checked by maintenance for proper functioning of fire alarm when opening. As per hospice nurse, the RP wanted R #6 to be transitioned to a regular wheelchair for now. Therapy to evaluate. A discussion occurred with R #6 about the RP's requests, and he agreed to them. Resident rights, out on pass, and smoking policy/procedure were discussed with the RP and R #6. Both parties verbalized understanding. - 07/08/24 at 2:30 PM, documented by an RN indicated: Hospice nurse gave new order for UA which was collected. Results were pending. - 07/12/24 at 2:42 PM, documented by RN C indicated: Relayed UA results to hospice nurse. R #6 continued to take prophylactic antibiotics for recurrent UTI. No new orders given. - progress notes from 07/08/24 to 07/16/24 reflected staff continued to monitor R #6 and R #6 did not exhibit elopement or exit seeking behaviors. (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 the Provider Investigation Report dated 07/13/24 reflected the incident on 07/08/24 at 4:48 AM was reported on 07/08/24 at 5:20 PM. At 4:48 AM, the ADM received a call from the night nurse to inform them that R #6 was identified outside of facility grounds. R #6 was located and returned safely to the facility. R #6 stated he left to go to the corner store to buy cigarettes. Head-to-toe inspected, no injuries noted, and R #6 was noted to be more confused than baseline. Provider Response: monitor closely, 1:1 to care for remainder of shift, and do visual checks often, and hospice to visit. Investigation attached. Conclusion: The facility completed a thorough investigation that included the review of the resident's clinical record, interviews with the staff and resident, and the resident's responsible party, consultation with the primary care provider and hospice services, review of the facility's policies and processes, and physical plant elopement risk points. During the facility investigation, it was evident that R #6 exited the front lobby door while staff were working in other hallways and were not able to witness the resident exit. The resident exited his hall at 2:14 AM (3:14 AM, video footage timestamp incorrect) and exited the facility front door at 2:15 AM (3:15 AM). It took the resident approximately one (1) minute to exit the facility in his wheelchair after leaving his room. R #6 exited the front door of the facility on 07/08/24 at approximately 2:15 AM (3:15 AM). R #6 was found safe at the corner store approximately 1 block (0.5 mile away according to a web search) from the facility with LE, who contacted facility staff for pick up. The resident was returned to the facility without injury or adverse effects to his health. Again, to repeat, there were no signs or symptoms of abuse, neglect, distress, or bodily injury noted. The facility felt confident the investigation revealed this was an unpredictable and isolated event which was unavoidable and not related to neglect. The resident never demonstrated behavior, voiced desire, or had assessment results that would have indicated he was a risk for elopement. The facility took all measures possible to ensure this does not re-occur with R #6 or any other resident in the facility. Investigation findings: Unconfirmed. Provider Action Taken Post-Investigation: Staff in-service conducted regarding abuse/neglect/exploitation, reporting incidents, elopement, change of conditions, 100% in-service for all staff on elopement and facility investigation conducted regarding allegation of abuse/neglect with findings unconfirmed. Signed by the ADM on 07/13/24. Interview with R #6 on 07/10/24 at 11:30 AM. R #6 said he left the other night. R #6 could not provide details of where he went. R #6 said he did not tell anyone he was leaving. R #6 said the police brought him back. R #6 appeared confused and did not continue the interview. Interview with R #6's RP on 07/10/24 at 11:45 AM. The RP said she had no concerns with the care provided to R #6 at the facility. The RP said she was aware of R #6 eloping. The RP said she received a call from the nurse on 07/08/24 at around 4:48 AM to let her know about the situation. The RP said when she arrived at around 6 AM, the DON and ADM were already at the facility. The RP said she did not believe the staff failed to do something, but she just thought about all the worst-case scenarios and she just worried. The RP said she did not want to think about all the things that could have happened. The RP said R #6 did not have a history of leaving like he did. The RP said R #6 did not say he wanted to go home or show any sign of wanting to leave. RP said R #6 had been doing well. The RP said R #6 had a UTI, but he got UTIs frequently, and never tried to leave. Interview with corner store Manager on 07/10/24 at 8:20 AM. The Manager did not have any knowledge or information regarding the incident involving R #6. The Manager reassured her staff would have notified her of such incident but did not mention that they called LE for R #6. The Manager did not wish to provide the contact information for the clerk that worked at the time of incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LE attempted on 07/10/24 at 9:40 AM. LE was not working, and a message was left requesting a callback. Interview with RNA A on 07/10/24 at 10:25 PM. RNA A worked the 10 PM-6 AM shift. RNA A said she worked on 07/07/24-07/08/24 with R #6. RNA A said she was assigned to R #6's room in the 700 hall, but she and the other RNA would help each other out as needed for all residents on the north side. RNA A said they rounded on the residents every 2 hours and as call lights were turned on. RNA A said R #6 was very independent and he was known to get up in the middle of the night. RNA A said R #6 would self-transfer to his wheelchair, go down the hall to the south side, and go back to his room. RNA A said R #6 had never left the facility. RNA A said he always went back to his room. RNA A said R #6 did not say he wanted to go home or to the store. RNA A said R #6 did not exhibit different behaviors, it was like any other night. RNA A said nobody knew that R #6 was going to elope. RNA A said the last time she saw R #6 was around 2 AM during their rounds. RNA A said she saw him in the motorized wheelchair in the hall. RNA A said after that she did not remember seeing him. RNA A said she continued answering lights and helping the other RNA. RNA A said they did help in all 3 halls as needed on the north side. RNA A said around 4 AM, she had started rounds in the 800 hall and LVN A informed her that R #6 was at the corner store. RNA A said LVN A and RNA B left to bring R #6 back. RNA A said she continued with the rounds in the meantime. RNA A said they brought R #6 back and he was not injured or in distress. RNA A said R #6 did not tell her anything about where he went or why, he just went to his room and laid down. RNA A said she knew to look for signs or symptoms of UTIs and would report it to the nurse. RNA A said she could not remember if R #6 had a UTI, but he did not appear confused that night. RNA A said he conversed with them, looked out for his roommate, and had no signs of confusion when she worked with him. RNA A said they completed their rounds like usual that night like they always did. RNA A said she did not fail to complete the rounds every 2 hours. RNA A said they did rounds, answered call lights, and got busy at times. RNA A said R #6 had never done what he did, and they had no reason to monitor him for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RNA B on 07/10/24 at 10:50 PM. RNA B worked the 10 PM-6 AM shift. RNA B said she worked on 07/07/24-07/08/24 with R #6. RNA B said she had seen R #6 around 2 AM. RNA B said she had seen him in his room and in the hallway in his wheelchair. RNA B said she believed she might have been in another resident's room at the time when LVN A informed them that R #6 was gone around 4 AM. RNA B said R #6 was very independent and had never tried to leave. RNA B said R #6 went to the restroom, got coffee down the hall on the south side, and went back to his room. RNA B said R #6 never appeared confused, at least not during their shift. RNA B said R #6 was able to self-transfer from the bed to the wheelchair and from the wheelchair to the bed. RNA B said R #6 did not like for them to assist him much. RNA B said it was normal for R #6 to be awake at that hour of the night. RNA B said they rounded on the residents every 2 hours. RNA B said she and RNA A helped each other out to care for the residents in the 600, 700, and 800 halls (north side). RNA B said R #6 never said he wanted to leave or that he wanted to go to store. RNA B said R #6 smoked a lot but understood that there were smoke breaks, and he never tried to go outside during the overnight hours to go smoke. RNA B said LVN A asked her to help him bring R #6 back. RNA B said they went in her car so R #6's wheelchair would fit in the back of her car. RNA B said when she arrived at the corner store, LE was outside with R #6. RNA B said R #6 recognized her and LVN A. RNA B said R #6 did not appear confused. RNA B said the corner store clerk said that R #6 had asked for cigarettes. RNA B said the clerk spoke more to LVN A. RNA B said LE said he wanted to make sure that R #6 was safe and LE followed them to the facility. RNA B said LE spoke to RN A, then left. RNA B said LVN A assessed R #6 and RNA B continued with rounds and assisted other residents. RNA B said R #6 did not tell her anything on the way back to the facility such as where he went or how he left. RNA B said R #6 told LVN A that he went to the store. RNA B said LVN A continued to interview and assess R #6 but she continued with rounds so she was not sure what else he said. RNA B said if the resident had a UTI, they did inform them during the report or shift change. RNA B said she did not know if R #6 had a UTI, but he was known to have UTIs. RNA B said sometimes they did have to monitor the residents more when they had a UTI because they were very confused. RNA B said R #6 was not confused, at least it did not appear like that to her. RNA B said R #6 always had a staff with him for now and they were checking on him more frequently. RNA B said she did not know which door R #6 exited through. RNA B said the doors at the end of the halls would sound when they opened them, but the door alarms never sounded that night. RNA B said the front door was not locked before. RNA B said she was not sure if it was locked when she arrived for her shift today, she did not pay attention. RNA B said she had been in-serviced on elopements before the current incident and a similar incident had never happened before. RNA B said they completed the rounds on time, rounded at 2 AM and then again at 4 AM but they were in other residents' rooms around that time. RNA B said especially around the 4 AM shift, the residents usually started waking up and pressed the call lights more frequently. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with RN A on 07/10/24 at 11:45 PM. RN A said he worked on 07/07/24-07/08/24 with R #6. RN A said he worked on the south side of the building but that night he was in/out of another resident's room that had declined. RN A said he might have been in that resident's room when R #6 was on the south side or exited the building. RN A said he was informed by LVN A that LE called the facility to inform them that R #6 was at the corner store. RN A said LVN A and RNA B left to bring R #6 back. RN A said R #6 arrived with RNA B and LE had escorted them. RN A said LE asked him for R #6's DOB and wanted to make sure he was a resident of the facility. RN A said LE left, and he assisted R #6 into his wheelchair. RN A said LVN A assessed R #6. RN A said he assisted a bit but then returned to his residents. RN A said R #6 was not injured. RN A said R #6 was known to get up throughout the night. RN A said R #6 was self-sufficient, went to the restroom, got coffee by the kitchen area, and went back to his room. RN A said that was his normal routine. RN A said R #6 did seem confused this night. RN A said R #6 had a diagnosis of dementia and his cognition fluctuated. RN A said R #6 had recurrent UTIs, but he did not know if R #6 was being treated for that. RN A said UTIs were reported in the shift change, as well as medication changes. RN A said LVN A was assigned to R #6 that night. RN A said if there was a change of condition, the RNAs would also be informed so they ensured to monitor them for any changes. RN A said he kept track of the residents that might have a change of condition and if they had a UTI, that might cause confusion. RN A said he was not sure if R #6 was being treated for a UTI or if the staff were informed that night. RN A said even if R #6 was confused, he had never tried to leave like this. RN A said the most R #6 would do was get up, get coffee, and go back to his room. RN A said the nurses did rounds, the RNAs did rounds, every 2 hours or as needed. RN A said before the incident happened, the front door was not locked. RN A said he was not sure if the door would be kept locked. RN A said LVN A completed the cognitive and body assessment for R #6. RN A said they notified the DON, ADM, RP, and MD. RN A said R #6 did not say anything like where he went or really talk. RN A said LVN A might have gotten more information from him. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LVN A on 07/11/24 at 8:20 AM. LVN A said he worked on 07/07/24-07/08/24 with R #6 in the 700 hall. LVN A said he was assigned to the 600, 700, and 800 halls (north side). LVN A said when he arrived for his shift, he got report, did his round, and made sure everyone was accounted for with the call light nearby, like usual. LVN A said LE called him on the phone at around 4 AM, to inform him that R #6 was at the corner store. LVN A said that was when he was aware that R #6 was missing. LVN A said he had seen R #6 around 2 AM, down the hallway and in his bed. LVN A said R #6 was able to transfer himself in and out of bed and it was not unusual for him to get up around that time. LVN A said R #6 would go to the restroom, go down the hall to the south side, get coffee, but he would always go back to his room. LVN A said R #6 had never tried to leave before. LVN A said R #6 was a smoker and there were no smoke breaks during the overnight hours, but R #6 never tried to go outside to smoke during the night. LVN A said if the residents went out on pass, there was a binder in the front to sign in and out, but R #6 would never try to go out in the middle of the night like that. LVN A said R #6 never said he wanted to go home or that he wanted to go to the store. LVN A said R #6 did not exhibit any indications that he would elope. LVN A said R #6 was sometimes confused, probably because of the UTI he kept getting and his diagnosis of dementia. LVN A said R #6 had recurrent UTIs, so it was hard to say if he was confused because of the UTIs or the dementia. LVN A said other times that he had UTIs, he never tried to leave. LVN A said if a resident had a UTI, the staff were informed. LVN A said the RNAs knew to report any changes such as behavioral changes or altered mental status. LVN A said even if they did not have a UTI, the staff knew to report any changes. LVN A said the staff knew R #6 had a UTI. LVN A said it was around maybe 4 AM when LE called. LVN A said he and RNA B took off right away to the store in their vehicles. LVN A said they did not use the facility van because they did not have the keys, plus they did not want to waste time. LVN A said when they arrived, R #6 was sitting outside with LE. LVN A said the store clerk asked him for the facility's phone number to have just in case. LVN A said the clerk did not mention anything else. LVN A said he did not know how they figured out if that was that facility. LVN A said maybe they just called different locations. LVN A said LE wanted to know his name and DOB to release R #6 to him. LVN A said they brought R #6 back to the facility in RNA B's vehicle. LVN A said LE helped to put R #6 in the car, ensured he was buckled, and brought him back safely to the facility. LVN A said LE followed them to the facility. LVN A said R #6 said he wanted to purchase a lighter but was not able to get one. LVN A said he completed the head-to-toe assessments and the other assessments for R #6. LVN A said he was not injured. LVN A said he was confused but the confusion was normal to his baseline. LVN A said he completed the BIMS and the elopement assessment. LVN A said he did not remember how he scored but it should be documented in his file. LVN A said the RNAs conducted their rounds appropriately and he did not believe they failed to do something. LVN A said sometimes the RNAs went into rooms together to help each other out or maybe help the nurses too. LVN A said he also completed his rounds that night and might have been busy with other residents when R #6 left the facility. LVN A said they brought him back safely, notified all parties, doctor, family, hospice, DON, administrator, and followed the protocol. LVN A said R #6 was at the corner store on the intersection about 0.5 mile away. LVN A said even before the incident happened, they had in-services in the past for elopements and this was not something new that they were learning or trained them on. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the DON on 07/10/24 at 8:50 AM. The DON said he was aware of the incident regarding R #6 eloping on 07/08/24. The DON said the staff had just seen him and checked on R #6 around 3:30 AM, and he was doing fine. The DON said the facility got a call around 4:50 AM that R #6 was at the corner store. The DON said LVN A and RNA B went to pick him up and brought him back. The DON said R #6 was not injured. The DON said the staff had already called him and so he and the ADM showed up to the facility. The DON said he called the corner store and spoke to the store clerk. The DON said the clerk said that R #6 went into the store, asked for cigarettes and a lighter, but then R #6 said he forgot his money. The DON said that R #6 did not remember which way to get back to the facility. The DON said the clerk said he called LE and LE called the facility to see if R #6 was a resident there. The DON said they reviewed the cameras and noted that R #6 left through the front door which was not locked and did not have any chime or alarm. The DON said after R #6's elopement, they installed a chime at the front door so every time the door was opened a chime sounds. The DON said he explained to staff that the chime was to alert them that there was someone at the door. The DON said during the nighttime, nobody came in and out, so staff knew that the chime came from the front door. The DON said the other doors had an alarm that would go off but that was a different alarm system and made a different noise. The DON said the doors were checked and all the door alarms functioned properly. The DON said there was nobody at the front desk when R #6 exited the front door. The DON said nobody knew he had left. The DON said R #6 had not exhibited exit seeking behaviors or said he wanted to go home/store. The DON said there were no indications that he would leave. The DON said R #6 had never eloped before. The DON said R #6's last BIMS was 11 (moderately cognitively impaired), but then when they brought him back, they conducted the BIMS and it was a 3 (severely cognitively impaired). The DON said then when R #6 was assessed again, hours later or the next day, his BIMS was at 11 again. The DON said R #6 was confused and they had been treating him for a UTI. The DON said R #6 was on hospice due to COPD and the hospice nurse had said to put him on antibiotics prophylactically (preventative measure) without labs because since he was on hospice, they usually did not take blood or do labs. The DON said the doctor said to do a urine test to see if they needed to change the antibiotics after the incident happened. The DON said they placed R #6 on 30-minute checks for 3 days, and he had been doing well. The DON said they discussed with the RP that if he had more behaviors or began to exit seek, that they would maybe need to move him to a memory care unit, but the RP did not want that. The DON said R #6 was a smoker, but he understood there were certain times to smoke. The DON said R #6 had a motorized wheelchair, but the RP requested for him to only use the regular wheelchair to prevent any further incidents in the meantime. The DON said R #6 was known to be awake and up in his wheelchair during the night, but he would never try to elope. The DON said that same day on 07/08/24, they initiated elopement assessments on every resident and no other resident triggered for high risk. The DON said there were 3 ambulatory residents, but they were not at risk of elopement according to the assessments. The DON said they also completed in-services for all staff, checked all doors/alarms, installed the front door chime, and began elopement drills. Interview with the ADM on 07/10/24 at 9:05 AM. The ADM said when R #6 eloped through the front door, the front door was not locked, there was nobody assigned to the front desk, and there was no alarm. The ADM said that was how the facility had always done things and no elopement incident had occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676042	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McAllen Transitional Care Center	2109 South K St MC Allen, TX 78503

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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	Interview with the DON on 07/10/24 at 1:55 PM. The DON said R #6's care plan indicated to monitor for symptoms regarding UTIs. The DON said a UTI could cause confusion and he was also on antibiotics so they would monitor daily for altered mental status which meant alertness, cognition, and responsiveness. The DON said R #6 had intermittent confusion, so it was hard to say if the confusion resulted from the UTI or his dementia. The DON said at night, nobody was at the front desk, and it had always been like that. The DON said all the doors opened and had an alarm to alert except the front door. The DON said the front door did not have an alarm or chime until now. The DON said there had never been an issue regarding the front door. The DON said R #6 was able self-transfer to the wheelchair. The DON said some days he required more assistance than other days, depending on his day. The DON said R #6 had been declining a lot the past few weeks which was why he got admitted to hospice. The DON said R #6 had COPD and his lungs were very poor, but he continued to smoke. The DON said RP did not want to take away that joy of smoking and it was his right to smoke. The DON said he believed it was around 3:30 AM that the staff last saw R #6 and he left around 3:37 AM, but the time stamps on the video footage were not correct so he was not sure on the times. The DON said LE called the facility around 4-4:30 AM. The DON said the staff called the ADM, the nurse called the DON, then ADM called the DON to make sure he knew. The DON said he got the call at 4:45 AM from the nurse, and R #6 was already back in the building when they called him. The DON said he arrived at the facility around 5-5:15 AM. The DON said the staff rounded every 2 hours and the staff had rounded with R #6 within the 2-hour period. The DON said R #6 got up during the night, got coffee, or roamed around inside the building but never tried to leave. The DON said that was what the night staff told him. The DON said the staff would check he got coffee and went back to his room. The DON said during the rounds, the staff had to make sure they saw each resident, even if they did not require assistance, make sure they put eyes on them. The DON said the staff would have noticed during the next round that R #6 was missing. The DON said at night, the building was very quiet so the chime installed would echo throughout the building and alert someone was at the front door. Observation/review on 07/10/24 at 4:30 PM revealed the ADM showed the Investigator the video footage of R #6 leaving the facility. The video footage timestamps were incorrect by about 3 hours ahead of actual time. At around 3:16 AM, R #6 exited the building through the front door, which was not locked, and he left the facility grounds on his motorized wheelchair. At around 4:25 AM, LVN A and RNA B left in their cars. At around 4:38 AM, staff returned with R #6 in RNA B's vehicle. LE followed them to the facility. LE spoke to RN A and left. RN A and RNA B assisted R #6 into his wheelchair and back into the facility. Interview with LE attempted on 07/10/24 at 9:50 PM. LE was not working on this night, and a message was left requesting a callback. Interview with the DON on 07/15/24 at 4:10 PM. The DON said they did not know R #6 would elope as he did not have any history or behaviors. The DON said R #6 was not injured and did not have a negative outcome from the incident. The DON said he did not believe R #6 would have been injured from the incident as he was aware of what he was doing. The DON said R #6 told him that se fue por el caminito (followed the sidewalk) and he arrived at the store safely. The DON said R #6 got a little confused and did not know how to come back and knew to ask for help. Record review of a Google.com search conducted on 07/16/24 reflected the corner store was approximately 0.5 mile away from the facility. (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 Weather.com search reflected the temperature for 07/08/24 at around 3-4 AM was approximately 80 degrees Fahrenheit. Record review of the Elopement/Unsafe Wandering Policy dated June 2018 Revised on: December 2023 Policy: It 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 or a safe area without the facility's knowledge, authorization (examples: an order for discharge, appointment, or leave