

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Magnolia Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 N Magnolia Luling, TX 78648	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 3 residents (Resident #1) reviewed for accidents and supervision, in that: The facility failed to ensure Resident #1, who ambulated with the help of a walker, received adequate supervision to prevent him from exiting the facility with a busy highway at the front, undetected on 06/09/25. The non-compliance was identified as Past Non-Compliance. The Immediate Jeopardy (IJ) began on 06/09/25 and ended on 06/11/25. The facility corrected the non-compliance before the investigation began on 06/25/25. This failure could place the residents with exit seeking behaviors at risk for injury or death. The findings included: Record review of Resident #1's face sheet dated 06/25/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included heart failure, lack of coordination, unsteadiness on feet, hypertension, muscle wasting and atrophy, difficulty in walking, pain, incontinence, and dementia.</p> <p>Record review of Resident #1's initial MDS assessment dated [DATE] reflected a BIMS score of 09, indicating Resident #1's cognition was moderately impaired. The MDS stated he had no indication of psychosis or behavioral issues.</p> <p>Record review of Resident #1's care plan dated 04/29/25 reflected Resident #1 had elopement risk and a history of attempts to leave the facility unattended with poor safety awareness. The relevant intervention was, place him in a secured unit for personal safety. Other interventions were, distracting resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books or any other activities that resident prefers. On 6/9/25 an additional intervention of notifying the ADM/DON if resident was out of cigarettes, was added as Resident #1 appeared stressful when he did not have cigarettes.</p> <p>Record review of Resident #1's elopement evaluation dated 06/09/25 reflected Resident #1 had a score of 6 out of 7 indicating he was at high risk for elopement. The initial elopement assessment conducted by DON on 04/29/25 next day after his admission indicated Resident #1 was at high risk of elopement with history of attempts when he was at the previous facility.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of a FRI dated 06/10/25 reflected, on 06/09/25 at about 7:41am the facility first learned about the elopement of Resident #1. On 06/09/25 CNA A noted resident in his bedroom asleep at about 5:45 am. CNA B went to check on him at about 7:00am to help him prepare for breakfast and at that time it was realized that he was not in his room. The facility building and grounds were searched for locating him. By 7:41am it was confirmed that resident was not in the premises of the facility. It was believed Resident #1 escaped through a window, as during the search the staff noticed a broken window in the dining area of the memory care unit with the screen pushed out. The resident was located approximately a mile away from the facility and staff brought him back to the facility.</p> <p>During an interview on 06/27/25 at 4:10pm CNA A stated on 06/09/25 she arrived at the facility at about 5:29am as usual for her shift. CNA A stated she had seen Resident #1 in his room at about 5:45 am sound asleep. She said at about 7:00 am another staff member who went into Resident #1's room stated he was not in his room. CNA A stated she began to look in the dining area and noticed Resident #1's walker by the back table and the window was broken with its screen off. She said an immediate search was initiated and resident was not found on the premises. The DON and AD began to search outside the memory care unit and outside of the facility building. She stated she was told later Resident #1 was located by the park about a mile away from the facility and staff brought him back to the facility. CNA A stated she received an in service on elopement on 06/09/25 and elopement drill and Inservice on the missing person policy and procedure on 06/10/25.</p> <p>During a phone interview on 06/25/25 at 4:20pm CNA B stated on 06/09/25 she was working on the 6:00pm to 6:00am shift. She said when Resident #1 went missing in the morning she searched for him in the bathroom, resting areas and out in the courtyard of the memory care unit. CNA B stated generally Resident #1 was quiet and calm however there were moments he would be aggravated. CNA B stated while Resident #1 was on constant observation by a staff , he made another attempt to break the window in the next day after the incident of elopement occurred. She stated later he was relaxed and appeared settled down without any further attempts. CNA B stated she received an in service on elopement on 06/09/25 and elopement drill and Inservice on the missing person policy and procedure on 06/10/25.</p> <p>During a phone interview on 06/25/25 at 4:45pm CNA C stated she worked at the facility's memory care unit in the 6:00pm to 6:00am shift. She stated she knew Resident #1 was at high risk of elopement however never made any attempt since his admission until 06/09/25. She stated she did not know the triggering factor for his elopement. CNA C stated when she came to know Resident #1 was missing, she let the nurse in charge and others know about it and started searching everywhere. CNA C stated she received an in service on elopement on 06/09/25 and elopement drill and Inservice on the missing person policy and procedure on 06/10/25.</p> <p>During an interview on 06/25/25 at 11:30am the AD stated she came into the facility on [DATE] as usual at about 5:30 am to work. She said at about 7:30am the staff let her know that Resident #1 was missing from memory care. She stated she with the help of the floor plan of the facility and checked everywhere inside the facility. The AD stated when she could not find Resident #1 on the facility premises, she took her car and drove through the highway for about two miles looking for him. The AD said when she returned after 30 minutes unsuccessfully, there was police at the facility for searching Resident #1. The AD stated she received an in service on elopement on 06/10/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/25/25 at 10:45am the DON stated the staff came to know Resident #1 was missing, at about 7:00am . He stated everyone was looking for him everywhere and meanwhile the staff called 911 for police help. He stated staff found Resident #1 about a mile away after about 2 hours. He added, considering Resident #1's condition he was not able to walk that far, and he was made to believe that he might have asked for a lift to a passenger for transportation. The DON stated the moment Resident #1 arrived back at the facility he did a head-to-toe assessment. The DON stated resident had no injuries, deformities, or any pain at that time or afterwards. He said Resident #1 was presented as calm and humorous after his return to the facility. The DON stated as per records Resident #1 made elopement attempts in the past while he was in another facility. He said Resident #1 had long history with TDC and this had taken into consideration while making decisions. He added Resident #1 was placed in the memory care unit as he was at high risk for elopement when he was initially admitted to the facility. The DON said Resident #1 was on 1:1 after the elopement on 06/09/25 and off from it only on 06/24/25 when the MDT team determined that he was safe. The DON stated Resident #1 might have eloped through one of the windows in the dining room in memory care as staff observed it was broken. He said, staff observed a chair in the backyard towards the fence and it was believed Resident #1 might have used the chair to climb up the fence. The DON stated the triggering factor for his elopement was not clear however it was observed that Resident #1 got stressed when his stock of cigarettes got depleted. The DON said recently he ran out of cigarettes due to issues with money from social security. He said the ADM decided to buy cigarettes for him out of pocket until he received money from social security, to keep Resident #1 free from the thoughts of elopement. DON stated he conducted an audit on all residents at the facility to make sure that an elopement risk assessment was conducted on all residents.</p> <p>During an interview on 06/25/25 at 1:35pm the ADM stated the resident was last seen at the memory care unit at 5:45am and the facility came to know about his elopement at about 7:00am. She said the police were informed to get help in the searching process and eventually staff located Resident #1 by a park about one mile away from the facility. The ADM stated Resident #1 said he was walking from the park to the store to cash in a lottery ticket. She stated Resident #1 was particular about having cigarettes consistently and due to some delayed social security payments, he ran out of cigarettes at the time of elopement . She said most likely this triggered him to get out of the facility to procure cigarettes by some other means. The ADM stated it was believed he might have escaped through a window by breaking the glass, stepped out and then by using an unsecured chair in the backyard jumped out of the fence. She stated immediately after Resident #1's return an assessment had been completed to make sure he was unhurt and safe. The ADM stated Resident #1 was under 1:1 observation until 06/17/25, he was referred to psychiatric service and a psych evaluation was completed. A QAPI meeting was conducted, and it was decided to help Resident #1 financially if he ran out of money to ensure an uninterrupted supply of cigarettes. She stated currently the chairs in the backyard were fastened with chains and soon will be anchored to the ground permanently with concrete. The ADM stated she was planning to change the glass panels of all the windows in memory care with non-shatter window glass for further protection from elopement by residents in the future and started collecting quotes for the work from contractors.</p> <p>During an observation on 06/25/25 at 11:30am of the window in memory care revealed that broken glass was replaced. An observation on 06/25/25 at 5:05pm of the backyard revealed the facility was enclosed by a fence. There were two gates on the fence that were locked with padlock. There were two chairs on the patio that were fastened with chains to the wall and not removable.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review on 06/25/25 of the 1:1 observation check sheet revealed Resident #1 was on 1:1 on arrival back to the facility on [DATE] until 06/24/25. Record review of the Inservice revealed all the staff who worked in the memory care unit were in serviced on Elopement- How to avoid an elopement , What to do during an elopement</p> <p>Record review of the facility's policy Wandering and Elopement revised in 03/2019 reflected: Policy Statement The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.</p> <p>Policy Interpretation and Implementation:1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.2. If an employee observes a resident leaving the premises, he/she should:a. attempt to prevent the resident from leaving in a courteous manner;b. get help from other staff members in the immediate vicinity, if necessary; andc. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.3. If a resident is missing, initiate the elopement/missing resident emergency procedure:a. Determine if the resident is out on an authorized leave or pass;b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; andc. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (i.e., emergency management, rescue squads, etc.).4. When the resident returns to the facility, the director of nursing services or charge nurse shall:a. Examine the resident for injuries.b. Contact the attending physician and report findings and conditions of the resident;c. Notify the resident's legal representative (sponsor);d. notify search teams that the resident has been located;e. complete and file an incident report; andf. document relevant information in the resident's medical record.</p> <p>Record review and verification on 06/25/25 of the corrective action implemented by the facility beginning on 06/09/2025 reflected: 1. An elopement risk reevaluation was completed on Resident #1 after the incident on 06/09/25 . Record review of Resident #1's Elopement Evaluation dated 06/09/25 reflected Resident #1 was at high risk for elopement.</p> <p>2. Resident was on 1:1 until 06/17/25 in the memory care unit. Record review of the One to one Monitoring form revealed resident was on 1:1 began at 9:00am on 06/09/25 and discontinued on 06/17/25 by the MD.</p> <p>3. A Psychiatric evaluation was completed.Record review of the psychiatric periodic evaluation dated 06/18/25 reflected a psychiatric evaluation conducted with Resident was referred to provider by DON for psychiatric evaluation and elopement as the chief complaint.</p> <p>4. A QAPI meeting to discuss the elopement incident .Record review of QAPI Action Plan dated 06/09/25 revealed an Ad. Hoc QAPI meeting conducted on 06/09/25 with MD attended remotely.</p> <p>5. The facility made arrangements to ensure Resident #1's stock of cigarettes would be replenished before finished. Record review of the care plan dated 06/09/25 revealed this arrangement was incorporated in the care plan.</p> <p>(continued on next page)</p>		

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