| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676072 | A. Building<br>B. Wing | 07/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Corrigan Ltc Partners Inc | 300 Hyde St<br>Corrigan, TX 75939 |

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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>(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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received an accurate assessment, reflective of the resident's status for 2 of 7 residents (Residents #1 and #3) reviewed for accuracy of assessments. The facility did not accurately complete the MDS assessment to indicate Resident #1 eloped from the facility on 06/02/25. The facility did not accurately complete the MDS assessment to indicate Resident#3 displayed physical aggression toward another resident on 06/27/25. Findings included: Record review of Resident #1's face sheet dated 07/24/25 indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included unspecified psychosis (indicates the presence of psychotic symptoms that don't perfectly align with a specific diagnosis), lack of coordination (a condition characterized by difficulty in performing physical movements smoothly and accurately), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), and paranoid schizophrenia (mind doesn't agree with reality). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated she was usually able to make herself understood, usually understood others, had severe cognitive impairment (BIMS-3). Wandering was not indicated. Record review of Resident #1's care plan dated 02/1/2/25 indicated she was an elopement risk and wander guard was placed on 02/12/25. Interventions included distract Resident #1 from wandering and identify pattern of wandering. Record review of Resident #1's care plan dated 06/03/25 indicated she was an elopement risk, the wander guard was removed. Interventions indicated Resident #1 was placed on the secure unit due to poor safety awareness and wander risk. Record review of Resident #1's physician orders dated 04/07/25 indicated may have wander guard due to poor cognition and poor redirection. Record review of Resident #1's Elopement Risk assessment dated [DATE] indicated a score of 11 (high risk). Record review of Resident #1's Elopement Risk assessment dated [DATE] indicated a score of 17 (high risk). Record review of Nursing Progress note dated 06/03/25 at 2:39 a.m., completed by RN A, indicated EMT F with (named service) arrived at facility and approached RN A asking, Do you have a resident named (Resident #1)? RN A confirmed this. EMT F said, Well she fell at the apartment complex across the street; a resident of the apartments saw her fall and called 911. She's on my truck right now. She told us she stays here, and that she walked out the back door. Record review of the facility investigation dated 06/10/25 and completed by the Administrator, indicated the facility became aware of Resident #1 missing from the facility at 10:45 p.m. on 06/02/25 after she was returned to the facility by EMS. The facility confirmed Resident #1 as a Missing Resident. Record review of Resident #3's face sheet dated 07/23/25 indicated he was a [AGE] year old male, admitted on [DATE], and his diagnoses included dementia with agitation (state of restlessness, irritability, and emotional distress that can lead to aggressive behavior and is commonly observed in individuals with cognitive disorders), dementia with behavioral disturbance (refers to the changes in mood, perception, and behavior that commonly occur in individuals with dementia, significantly impacting their quality of life and caregiving), unspecified mood disorder (symptoms of a mood disorder but doesn't meet the full criteria for a specific condition), restless and agitation (state of severe restlessness or inner tension, often accompanied by feelings of irritability and mental distress, while restlessness refers to an inability to remain still, often due to anxiety or discomfort), and schizoaffective disorder (depressive type) (chronic mental health condition that combines symptoms of schizophrenia (such as hallucinations and delusions) with symptoms of depression. It is characterized by a mix of both psychotic and mood disorder symptoms.) Record review of Resident #3's quarterly MDS assessment dated [DATE] indicated he was sometimes understood and sometimes understood others and had severe cognitive impairment. There was no aggression toward others noted. Record review of Resident #3's care plan dated 06/27/25 indicated Resident #3 had the potential to be physically aggressive to peers and staff related to schizoaffective disorder depressive type and unspecified mood disturbance. Interventions dated 06/30/25 included assess and anticipate Resident #3's needs. Record review of facility investigation dated 07/02/25 indicated the facility reviewed the video play back and noted on 06/27/25 at 7:54 a.m., Resident #3 tried to grab food off of another resident's tray. The other resident pushed Resident #3's arm away and Resident #3 hit the other resident. A slap fight ensued and the other resident stood and punched Resident #3 in the left lower side of the face. The residents were separated. Resident #3 did not recall the incident. Resident #3 was placed on 1-1 until he was discharged to a behavioral unit for evaluation and treatment. During an observation and |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(continued on next page) |

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|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **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 remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents (Resident #1) reviewed for supervision to prevent elopement. RN A failed to ensure Resident #1's wander guard (a device designed to prevent wandering in the elderly) was functioning as required. The facility was unaware that on [DATE], Resident #1 eloped from the facility with a wander guard sometime after 8:15 p.m. (approximately) and was found on the ground at an apartment complex adjacent to the facility by EMS at approximately 10:30 p.m. Resident #1 was returned to the facility by EMS on [DATE] at approximately 10:45 p.m. An IJ was identified on [DATE] at 1:45 p.m. While the IJ was removed on [DATE] at 1:30 p.m., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not being properly supervised resulting in serious injury or death. Findings included: Record review of Resident #1's face sheet dated [DATE] indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included unspecified psychosis (indicates the presence of psychotic symptoms that don't perfectly align with a specific diagnosis), lack of coordination (a condition characterized by difficulty in performing physical movements smoothly and accurately), vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain), and paranoid schizophrenia (mind doesn't agree with reality). Record review of quarterly MDS assessment dated [DATE] indicated she was usually able to make herself understood, usually understood others, had severe cognitive impairment (BIMS-3). Wandering was not indicated. Record review of Resident #1's care plan dated [DATE] indicated she was an elopement risk and wander guard was placed on [DATE]. Interventions included distract Resident #1 from wandering and identify pattern of wandering. Record review of Resident #1's care plan dated [DATE] indicated she was an elopement risk, the wander guard was removed. Interventions indicated Resident #1 was placed on the secure unit due to poor safety awareness and wander risk. Record review of Resident #1's physician orders dated [DATE] indicated may have wander guard due to poor cognition and poor redirection. Record review of Resident #1's physician orders dated [DATE] indicated monitor placement for function wander guard QD and pm every shift. Record review of Resident #1's physician orders dated [DATE] indicated monitor placement of wander guard bracelet at left wrist every shift. Record review of Resident #1's Elopement Risk assessment dated [DATE] indicated a score of 11 (high risk). Record review of Resident #1's Elopement Risk assessment dated [DATE] indicated a score of 17 (high risk). Record review of Nursing Progress note dated [DATE] at 2:39 a.m., completed by RN A indicated on [DATE] at 10:45 p.m. EMT F with (named service) arrived at facility and approached RN A asking, Do you have a resident named (Resident #1)? RN A confirmed this. EMT F said, Well she fell at the apartment complex across the street; a resident of the apartments saw her fall and called 911. She's on my truck right now. She told us she stays here, and that she walked out the back door. Her only complaint is that she says she got bitten by ants on one of her hands. Do you want me to transport her, and if so, to which facility? RN A asked him, Does she have ant bites on her hand? He replied, I didn't see anything, but my partner is assessing her on the truck now. RN A printed up the Resident #1's face sheet and order summary for the EMS crew and a copy for the ER staff and asked him to transport her to (named hospital) for evaluation. RN A contacted the Administrator and DON by 10:58 p.m. Made facility-wide head count = 41. At 11:51 p.m. left detailed VM with RP. At 12:56 a.m., RN A received phoned report from (named hospital RN) and CT scans were negative, fractures were ruled out, and no injuries had been noted. At 1:57 a.m., Resident #1 returned to facility via EMS. At 2:12 a.m. RN A contacted NP. Received orders as follow: Maintain Q 15 monitoring and consider admission to The Secure Unit. RN A did not address Resident #1's wander guard placement or functionality. Record review of the facility investigation dated [DATE] and completed by the Administrator, indicated the facility became aware of Resident #1 missing from the facility at 10:45 p.m. on [DATE] after she was returned to the facility by EMS. She was transported to the hospital by EMS for evaluation and treatment. The facility initiated a head count for all residents, obtained a list of all residents with wander guards, wander guards were checked for expiration dates. Resident #1 returned to the facility and had no injuries. Resident #1 was placed on 15 minute checks upon return from the ER. Resident #1's wander guard was working upon |