

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676089	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/14/2025
NAME OF PROVIDER OR SUPPLIER  Winnie L Ltc Partners Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  2104 N Karnes Cameron, TX 76520	

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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 5 residents reviewed for accidents and supervision. (Resident #1)The facility failed to ensure Resident #1 received adequate supervision to prevent elopement. On 08/07/2025 at an unknown time Resident #1 eloped from the facility by reading the door code that was placed by the door and let herself out the front door. Resident # 1 was found by CNA A standing on the front porch when she left work between 6:30PM and 7:00PM. The non-compliance was identified as past non-compliance. The immediate jeopardy began on 08/07/2025 at 6:50 PM and ended on 08/08/2025 2:20 PM .The facility had corrected the noncompliance prior to the start of the survey. The facility had implemented corrective actions and returned to compliance before the investigation began. This failure had the potential to affect other residents and could result in residents not receiving appropriate supervision, placing them at risk for serious injury, harm, or death.During an observation on 08/13/2025 at 11:00 AM all exit doors were checked and locked and equipped with functioning alarms. Additionally, the outside of the entrance door had a sign stating , Please do not let Resident or person not in your party out of front door. The front door code was only posted from outside the door and written in words instead of numbers. Record review of Resident # 1's face sheet (unknown date) reflected an [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of dementia with severe other behavior disturbance (memory decline with acting out). Record Review of Resident #1's MDS quarterly assessment, dated 05/17/2025, reflected Resident #1 BIMS score of 10 which indicates a moderate cognitive impairment. Section C Cognitive - pattern reflected short -term memory loss.Record review of Resident #1's care plan dated 05/07/2025, reflected The resident is at risk for wandering; INTERVENTION: Provide structured activities: toileting, walking inside and outside, reorientation, strategies including signs, pictures and memory boxes. The resident is risk for falls r/t hx of falling and INTERVENTIONS: The resident needs activities that minimize the potential for falls while providing diversion and distraction, Resident resides in the Secure Care Unit, related to diagnosis of dementia (or related diagnosis) and risk for elopement. INTERVENTIONS: Admit to Secure Care unit per MD orders, allow resident to perform ADLs to their highest ability, offer assistance as needed, Assist and monitor resident for off unit activities if able and Engage resident in group activities and provide them with individualized meaningful activities.Review of Resident #1's incident report dated 08/07/2025 at 6:30PM reflected Resident walked out front door was seen by a CNA when they were leaving the building after their shift, CNA attempted to redirect resident back to the building, redirection unsuccessful, CNA came to get this nurse, and we assisted resident back inside. Immediate action: Resident to reside on secure unit due to history of elopement with active exit seeking behaviors. Vital sign as follows: BP 158/80 Temp 97.7 HR 68 RR 17 O2 98%. Physician, DON, Administrator and RP notified. Record review of a written interview given by ADM on 08/07/2025 to Resident # 1 and signed by Resident #1 and witnesses by [CNA A , in a question-and-answer format reflected, [ADM question]: were you trying to go somewhere earlier when you went out the front door. [Resident #1 answer] I went outside. [ADM question] yes, you went outside and was found right outside the front door. Were you needing anything that causes you to go outside? [Resident #1 answer] Well, no, not that I can think of. [ADM question] Are you doing ok right now do you need anything? [Resident #1 answer] I'm fine, thank you for asking. During an observation and interview with Resident #1 on 08/13/2025 at 12:15 PM revealed her walking around in the secure unit with an ink pen in her hand and asked for some paper to write on. Resident #1 was asked her name by Surveyor, and she stated her name and began to repeat yes are you here for me. Therefore, an interview with Resident # 1 was not completed. During an interview with CNA A on 08/13/25 at 1:00 pm, she stated she was leaving for work approximately at 6:30 PM and she observed Resident # 1 standing on the front porch of the facility. She stated Resident #1 was not walking and standing in one spot. She stated she asked Resident # 1 to come back in and she refused. Therefore, she opened the front entrance door to ask for help to MA B, but he could not hear her, so she ran back into the building and told the charge nurse (LVN A) Resident # 1 was outside and she would not come in. She stated LVN A came outside with her to assist, and Resident #1 had walked to unit 200 covered patio area . She stated she could not remember if Resident # 1 was sitting or standing on the patio; however, LVN A was able to get her to come back into the building. She stated Resident # 1 was assessed by LVN A. She stated Resident #1 knew how to read numbers, and it was possible she let herself out or she went out the door when a visitor left She stated Resident #1 use to</p>		