STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of League City	2620 W Walker League City, TX 77573

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. (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	**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 and that each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 1 resident (CR #1) reviewed for adequate supervision. The facility failed to provide adequate supervision to residents and adequate training of the staff regarding monitoring and documenting resident whereabouts (location) to mitigate accidents such as elopement when CR#1 eloped on 01/02/2025 and was found to have laceration to nose that required 3 sutures, a closed fracture to left wrist with splint in place, and a closed fracture to nasal bone. This noncompliance was identified as Past Non-Compliant Immediate Jeopardy (PNC IJ) was identified on 07/09/2025. The noncompliance began on 01/02/2025 and ended 01/31/2025. The facility corrected the noncompliance before the investigation began. The IJ began on 07/09/2025 and ended on 07/09/2025. The facility corrected the noncompliance by providing in-servicing and hands-on training regarding elopement for facility staff prior to surveyor entrance. This deficiency failure exposed residents living in the facility to safety hazards.Findings included: Review of face sheet dated 08/04/2022 reflected CR #1 was an [AGE] year-old female who admitted to the facility on [DATE] and discharged to a secure facility on 01/08/2025. Record review of CR #1 was admitted with the following diagnosis Alzheimer disease, Major Depressive Disorder, Anxiety disorder, Psychotic disorders with delusions due to known physiological condition, Osteoarthritis, Dysphagia, Ataxic gait, Generalized anxiety disorder, Insomnia, Dementia mild with psychotic disturbance, Deficiency of specified B group vitamins, Unspecified abnormalities of Gait and Mobility, Pain. Review of CR #1's initial nursing evaluation indicated she was alert to person, displayed some cognitive and communication deficits RT DX Alzheimer Dementia. A BIMS score was conducted upon admission on [DATE]. The results were 6 out of 15 and on 11/14/2024 another BIMS score was conducted which indicated a 5 out of 15 which indicated severe cognitive impairment. CR #1 was ambulatory. Her initial wandering evaluation conducted on 08/04/2022 indicated she was not a wandering risk. Record review of closed chart for CR #1 on 12/21/2024 at 12:26 PM indicated CR# 1 had a change of condition reported Altered Mental Status suspected UTI. On 01/01/2025 indicated Urinalysis results were negative. Review of exit seeking tool on 1/2/2025 reflected it was completed indicating CR #1 was wondering and exit seeking behaviors and on 1 or more occasions attempted to exit or has exited the facility to wander away, whether intentionally or due to confusion. Record review of CR #1's nursing note dated 01/02/25 indicated during shift Resident was seen walking around nurses' station with a bag stating that she was looking for her mom. shortly after resident walked to front desk looking for her mother and was redirected back to her room x2. At 2:15PM I was notified that resident was down the street past the daycare. Another resident's family member came into the facility and ask the front desk if we had a resident by the name of CR#1, front desk agreed. witness stated that CR#1 was down the street past the daycare in the middle of the street on the ground. Front desk quickly rushed to scene with phone in had calling administrator. By the time she made it to scene EMS and ADNS was on site. She then returned to facility and notified Nurse of what had happened. Activity Director stated that while working front desk a lot of family and new hires were there and she did not see resident go out the door, after redirecting her x2. Resident was transported to ER for further evaluation. MD and RP were notified. Record review of progress notes of CR #1 dated 1/3/2025, nurse notes indicated CR #1 returned to facility via EMS on 01/02/25 at 7:21PM. RP, NP, and DON notified of return. Resident has no new orders. Resident vitals 130/79, 73, 94% O2, 18, 97.5. Resident has laceration to nose with 3 sutures, closed fracture to left wrist with splint in place, and closed fracture to nasal bone. Resident has no complaints of pain or discomfort at this time. Resident was put on 1:1 with CNA at CR #1 bedside and as CR #1 walked around facility. Record review of CR #1's nurses notes dated 1/3/2025 at 12:19AM indicated CR #1 Resident continues 1:1 service. Resident currently walking around facility with sitter. Resident states she is waiting on her mom to pick her up. Resident redirected to bed. Record review of nurse progress notes CR#1 revealed CR#1 was on 1:1 until discharge date of 01/08/2025. Interview on 07/08/2025 at 2:45PM with Activity Director who said around 1:30PM on 01/02/2025 CR #1 went out the front door like she does all the time to sit on the front porch, it was very busy that day there was new hires and trainings going on. CR #1 usually just sits in the front and then comes back into the building. That day a unidentified person came into the facility and reported that it was a lady sitting in the median that look like she was from the nursing home I went outside to check and it was CR #1 in the