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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>676157 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                               | (X3) DATE SURVEY COMPLETED<br><br>04/11/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Ussery Roan Texas State Veterans Home |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1020 Tascosa Rd<br>Amarillo, TX 79124 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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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>Note: The nursing home is disputing this citation.</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26515</p> <p>Based on observations, interview and record review, the facility failed to ensure the residents environment remained free from accidents as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 12 residents (Resident #1) reviewed for accidents, hazards, and supervision.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility.</p> <p>The noncompliance was identified as Past Non-Compliance. The Immediate Jeopardy began on 3/7/25 and ended on 4/3/25. The facility had corrected the noncompliance before the survey began.</p> <p>This deficient practice could place residents at risk a serious injury or serious harm and placed residents at risk of heat or cold exposure, dehydration and/or other medical complications, or being struck by a motor vehicle.</p> <p>Findings included:</p> <p>Record review of Resident #1s Face Sheet, undated, documented a [AGE] year-old male was admitted to the facility on [DATE] with the following diagnoses: Sequelae of nontraumatic intracerebral hemorrhage (long-term effects of a hemorrhage stroke - bleeding into the tissues of the brain), hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), depression, type 2 diabetes (high blood glucose), convulsions (uncontrolled jerking, blank stares or loss of consciousness caused by abnormal electrical activity in the brain), reflux (stomach acid or bile irritates the food pipe lining), Benign Prostatic Hyperplasia without lower urinary tract symptoms (enlarged prostate but not cancerous), presence of prosthetic heart valve (an artificial device implanted to replace a damaged or malfunctioning heart valve), contusion and laceration of cerebrum with loss of consciousness greater than 24 hours without return to preexisting conscious level, with patient surviving (bruises and tears in the brain tissue), traumatic subdural hemorrhage with loss of consciousness (blood collects between the layers of tissue that cover the brain), hemorrhagic disorder due to extrinsic circulating anticoagulants (caused by blood thinners interfering with normal clotting factors)</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.

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| 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>Note: The nursing home is disputing this citation.</p> | <p>Record review of Resident #1's Care Plan, updated 3/7/25, documented the resident is an elopement risk related to history of attempts to leave the facility unattended. Interventions: distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Provide structured activities: Toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxed. Wander guard to wrist. Check functioning of secure alarm per order, may attempt to exit seek after having visitors.</p> <p>Record review of Resident #1's admission MDS resident assessment, dated 3/4/25, documented the resident scored 12 of 15 on a mini-mental exam for cognitive awareness and could answer questions correctly, independent with all ADLs but bathing, occasionally incontinent of bladder and bowel, 70 inches tall and 212 pounds.</p> <p>Record review of Resident #1's nurses notes documented the following:</p> <p>3/7/25 at 6:45 p.m. - This nurse notified via AC that Veterans spouse had contacted her via cell phone stating, My husband called me, and I can hear wind on the phone, and he says he doesn't know where he is. I can tell he is walking somewhere outside. This nurse and RN supervisor immediately began searching for the Veteran. Veteran was located at 6:30 p.m. approximately 500 feet from the facility seated on the ground. Veteran asked what happened and why he left the facility, Veteran responded, I was looking for my truck, it got stolen. Veteran assisted back to facility. Body audit completed: no injuries identified. Blood Pressure 131/75, oxygen saturation 95% on room air, 18 respirations, pulse 86. Wander guard placed to right ankle. One on one initiated upon return to facility. MD/NP ordered veteran be sent to ER for further evaluation. Spouse notified; Administrator notified.</p> <p>3/11/25 at 4:39 p.m. - Resident here with wife getting reacquainted with unit and staff, was pleasant in conversation, has wander guard to right ankle and is confirmed to be active. Educated resident and family on call light use and to notify staff for outings, as well as proper usage of sign out book - both able to verbalize understanding.</p> <p>Record review of Resident #1's Elopement evaluation, dated 3/7/25 at 9:58 p.m., documented the following:</p> <p>History of elopement while at home: no</p> <p>Wandering behavior, a pattern or goal-directed: no</p> <p>Wanders aimlessly or non-goal-directed: no</p> <p>Wandering behavior likely to affect the safety or well-being of self/others: no</p> <p>Wandering behavior likely to affect the privacy of others: no</p> <p>Recently admitted within past 30 days and has not accepted the situation: no</p> <p>Elopement Score: 1.0 (The resident was not an elopement risk)</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>Note: The nursing home is disputing this citation.</p> | <p>Record review of the Provider Investigation Report, dated 3/8/25 and filled out by the DON reflected Resident #1, who was independently ambulatory, interviewable and had the capacity to make informed decisions, approached LVN A and said he was looking for his friend. LVN A informed the veteran that she hadn't seen anyone, Resident #1 ambulated back down the hallway. Later, when LVN A was passing meal trays in the dining room, she saw Resident #1 ambulating down the main hallway. The AC received a call from Resident #1's wife who said her husband had called her and did not know where he was at, but he was outside and by a road. The AC immediately contacted the DON, who along with the RN supervisor, got in a car to search the outside of the facility while staff were searching everywhere inside the building. Resident #1 was found in the back of the facility sitting on the ground. Resident #1 was assessed head to toe, and he was assisted back to the community. Body audit was completed on Resident #1, no injuries identified. Placed on 1:1 monitoring pending transport to ER. Vital signs obtained, Blood Pressure 131/75, Oxygen 95% on room air, 18 respirations, pulse 86. Resident #1 does not complain or show signs of symptoms of any physical, mental, or emotional injuries or distress. Resident #1 does not have any ill effects on his psychosocial wellbeing and was sent to the hospital for evaluation and treatment for prior existing elevated INR that was being monitored and the facility was waiting for new orders. Resident #1 was admitted to ICU at the hospital and treated for subdural hematoma. MD/NP and spouse notified. All staff in-service was immediate for: Elopement Procedures and Managing Exit Seeking Behaviors, Resident Specific Care Plan Interventions and Identifying Trippers related to Exit Seeking Behaviors. Staff were also re-educated on the Elopement Risk Book and drills. The facility has created a new position and will hire a nighttime Concierge/Security to help support the community's front entrance. This position will support the community when the daytime concierge leaves for the day</p> <p>During an interview on 4/9/25 at 10:00 a.m., LVN A stated she was making her last rounds right before dinner, Resident #1 approached her and was looking for somebody with blonde hair and wearing boots. LVN A stated she told Resident #1 she had not seen anyone fitting that description and he ambulated away to his room. LVN A stated she was passing trays in the dining room between 5:00 p.m. and 6:00 p.m., when she saw Resident #1 in the main hallway and then she no longer saw him. LVN A stated in the middle of dinner, it was announced that Resident #1 was not in the building. LVN A stated it was not too long and Resident #1 was found. LVN A stated the RN supervisor and the DON assessed Resident #1 and he did not have any injuries. LVN A stated Resident #1 was sent to the hospital because his cognition was worse than it normally was. LVN A stated they had held Resident #1's Coumadin (blood thinner), because his INR was elevated and at the hospital, it was reported to staff the Resident #1 had a subdural hematoma. LVN A stated Resident #1 had not fallen but his INR was elevated, and he was more confused than usual, so they sent him out to the hospital. LVN A stated Resident #1 had since been discharged home.</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>Note: The nursing home is disputing this citation.</p> | <p>During an interview on 4/9/25 at 10:25 a.m., the DON stated Resident #1's spouse had called the AC, and she was frantic because Resident #1 called her and said he was outside. The DON stated they called a Code [NAME] due to a missing resident. The DON stated they announce overhead and then they started looking for the resident. The DON stated staff were stationed at the front and back doors. The DON stated the charge nurse would identify who stayed on the hall and who looked for the resident. The DON stated she called Resident #1's spouse and said she could not find him as she was outside and drove around the block but could not see him. The DON stated she received a call from the AC that Resident #1 was in the back of the facility sitting on the ground and that was where she found him. The DON stated Resident #1 told her he just sat down. The DON stated Resident #1 was assessed and was more confused than usual. The DON stated Resident #1 was being monitored due to an elevated INR and they were watching for any type of bleeding. The DON stated the RN Supervisor took Resident #1 to his room and assessed him again and there was not any injury. The DON stated during this situation, if passed a certain amount of time, the police would have been called if the resident could not be found. The DON discussed with the provider about the elevated risk because of his elevated INR and they did not know if he fell or just sat down, so they sent him out to the hospital for further evaluation. The DON stated a normal INR was supposed to be between 2 - 3, but Resident #1's was elevated at 3.9, so they held his coumadin dose. The DON stated they previously checked Resident #1's INR and it was 3.9, the INR was checked again at the hospital, and it was over 5. The DON stated she did not understand the rise in the INR because Resident #1 was not given any extra Coumadin because they had followed the provider orders and held the Coumadin dose. The DON stated Resident #1 had been taking Coumadin for a long time. The DON stated they drew INR twice a week and if the INR was abnormal, they draw an INR more often. The DON stated when Resident #1 returned to the facility, he did not have any order for Coumadin due to his high risk. The DON stated Resident #1 was talking in word salad (just jumbled words) before the hospital visit and when Resident #1 returned, he was back to his baseline. The DON stated Resident #1 had only been in the facility for a week as he came in for strengthening. The DON stated Resident #1 had a family member visit that day and he was confused and wanted to go home. The DON stated the interventions after the incident included placing a wander guard on the resident and checking on him every 15 minutes. The DON stated they felt Resident #1 walked out of the front door as the Concierge had left the facility.</p> <p>An observation on 4/9/25 at 11:10 a.m. of the area where the resident was found was at the back edge of the property. Along with the DON and CMS representative, revealed the back door was located between halls 400 and 500 which was always kept unlocked. The large patio had an open sidewalk on the right with no gate and at the end of the patio, there was a large open area, with no gate, leading out to the parking lot. The parking lot was crossed, and the far end of the property is an empty field with a housing development behind it and a road coming off of a main road which was used as a driveway to the back parking area.</p> <p>During an interview on 4/9/25 at 11:30 a.m., the AC stated Resident #1 was a new to the facility. The AC stated when Resident #1's family member called her because she received a call from Resident #1 who was outside somewhere. The AC stated Resident #1's family member said Resident #1 said he did not know where he was, so she notified the supervisor. The AC stated the DON called a Code [NAME] overhead and the DON and supervisor got in a car and went looking for Resident #1 while other staff were looking for him in the facility. The AC stated she called Resident #1's family member back to get his cell phone number so AC called him and asked him questions about what his surroundings looked like. The AC stated pretty soon, she heard the DON talking to him, so she knew Resident #1 was ok.</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>Note: The nursing home is disputing this citation.</p> | <p>During a telephone interview on 4/9/25 at 11:40 a.m., Resident #1's family member stated Resident #1 called her on his cell phone and said he was somewhere outside and told her he could not make it and he could not find his truck. Resident #1's family member stated she thought he was dehydrated as he had just got out of an intense therapy rehab center. Resident #1's family member stated Resident #1 had been at a rehab facility all last summer and was in intense therapy as his brain injury was very severe. Resident #1's family member stated Resident #1's memory was the problem now, but he was no longer on Coumadin because it was too dangerous for him to continue the medication due to his history of brain bleeds. Resident #1's family member stated Resident #1's INR was elevated and was 5.4 when he got to the ER, and he was dehydrated. Resident #1's Family member stated her husband was on the phone with the AC while staff were looking for him. Resident #1's family member stated he went to the hospital after that, was treated and came back to the nursing home for more rehabilitation and was discharged home with home health on 3/24/25. Resident #1's family member stated once they were aware he left the facility, they kept a better watch on him. Resident #1's family member stated right after the incident, a wander guard was placed on Resident #1 for his safety.</p> <p>During a follow-up interview on 4/9/24 at 11:55 a.m., the DON stated the back doors off of the great room had never been locked but they did have gates on the patio doors, but the owners of the building had them removed a few years ago because they thought it restricted residents too much.</p> <p>During an interview on 4/9/25 at 1:15 p.m., the Administrator stated they could also put a lock on the door that the residents could go outside on the patio and then once they were outside, they could push a button to come back in. The Administrator stated the Maintenance Man had put a chirping alarm on the door already but was looking to get more parts so the door could be locked. The CMS representative asked when the elopement happened - 3/7/25 and what is today's date - 4/9/25, so why did it take so long to act. The Administrator stated the security guard at night was working and they had been getting bids for alarms on the door.</p> <p>Record review of a bid sheet, dated 3/28/25, revealed a quote was submitted from a reputable company for locks for the facility at a cost of \$61,240.00. The quote was sent to the corporate office for further review and evaluation.</p> <p>Record review of the facility's undated policy titled, Elopement in the Long-Term Care Setting: Prevention and Response Protocol., documented the following:</p> <p>Code Green: Active Elopement:</p> <p>In our facility, Code [NAME] signals an active elopement. It means a resident is missing and immediate action is required.</p> <p>Elopement Response Procedure:</p> <ol style="list-style-type: none"> <li>1. Notify the Manger on Duty,</li> <li>2. Review the Sign-Out book to confirm where resident has been signed out by family member.</li> <li>3. Page the resident over the public address system to alert all staff members.</li> <li>4. Search the Facility - all rooms, hallways, and outdoor areas.</li> </ol> <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>Note: The nursing home is disputing this citation.</p> | <p>Social Worker was educated on 3/7/25 by DON on resident specific care plan interventions and identify triggers related to exit seeking behaviors.</p> <p>An Elopement Drill was conducted on each shift starting with evening shift on 3/7/25 and completing with night shift 3/8/25 by DON and/or designee.</p> <p>Elopement Risk book reviewed and updated by Social Worker/Designee on 3/8/25. This book contains identification information on residents at risk for wandering. Picture of resident as well as face sheet are included. Book is available to all staff with copy at receptionist desk and on each nursing unit. 100% of available staff were trained on the elopement book by DON/Designee on 3/7/25. All other staff were trained before their next scheduled shift on the elopement book.</p> <p>All doors with the wander guard system were checked to ensure proper function on 3/7/25 by facility maintenance staff. All door wander guards were functioning properly.</p> <p>Elopement risk was completed on all residents by DON/Designee by 3/7/25. Any resident identified with elopement risk had interventions in added. These include but are not limited to Wander Guard, Secure Unit, frequent checks, and the Care Plan updated. These updates reflect resident specific interventions. Residents with any risk had interventions implemented.</p> <p>3/10/25 - Security Staff job opening posted on hiring platforms for nighttime rounding, monitoring interior and exterior of facility examining doors to ensure they are functioning, secured and untampered.</p> <p>4/1/25 - All Security job openings were filled, and orientation completed. The start date of them working in their official capacity was 4/3/25 - all rounding sheets reviewed with no concerns, elopements, or significant findings.</p> <p>Elopement policy was reviewed with no updates required by the Regional Clinical Consultant.</p> |  |  |