STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676173	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenedy Health & Rehabilitation	7882 S Hwy 181 (No Mail Service) Kenedy, TX 78119

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and supervision, in that: The facility failed to ensure Resident #1 did not elope from the facility without staff knowing on the evening of 4/8/2024. The noncompliance was identified as PNC. The IJ began on 4/8/2024 and ended on 4/9/2024. The facility had corrected the noncompliance before the survey began. This deficient practice could place residents at-risk of harm, serious injury, or death. The findings included: Record review of Resident #1's admission record, dated 8/7/2024, reflected that Resident #1 was a [AGE] year-old male initially admitted on [DATE], with diagnoses that included unspecified dementia(group of thinking and social symptoms that interferes with daily functioning), paranoid schizophrenia (a disconnection from reality, including hallucinations and delusions with paranoia), and type 2 diabetes mellitus (long-term condition in which the body has trouble controlling blood sugar and using it for energy). Record review of Resident #1's quarterly MDS assessment, dated 6/21/2024, reflected that Resident #1 had a BIMS score of 12, indicating moderate cognitive impairment. Resident #1 was assessed for using a manual wheelchair and was assessed as, Partial/moderate assistance for the ability to walk at least 50 feet and make 2 turns, and for, the ability to walk at least 150 feet in a corridor or similar space. Record review of Resident #1's care plan dated 8/7/2024, reflected Elopement: Actual elopement. Resident left the facility unattended with interventions including, supervise closely and make regular compliance rounds whenever resident is in room. 1 on 1 frequent monitoring, Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes, Distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books with the date initiated 4/8/2024. (continued on next page)

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	Record review of Resident #1's elopement assessment from 1/10/2024 reflected Resident #1 as a low wander elopement risk and on 4/9/2024 as an elopement risk. Record review of Resident #1's nursing note, dated 4/8/2024, revealed , Med nurse asked staff for location of [Resident #1] for his 8pm nitro patch as he was not in room. CNAs stated they saw him sitting up front in TV room at approx [7:30-7:45 PM] when they started their round. At approx. 820 PM, all staff began searching, unable to locate res in facility. After all areas inside and perimeter searches, DON, Administrator notified @ approx. [8:46 PM]. 911 called @ [9:03 PM] by DON. [9:06 PM] [Responsible Party], notified and she was grateful for the all and asked for regular updated. [County] Sheriff Deputy, [County] and [municipality] PD, and [County] Fire Dept arrived on scene to search at approx. [9:08 PM]. Located resident at [9:53 PM] next door property sitting in a vehicle. Alert, oriented to person and place, stated he wanted to see his family so he started walking. No injuries or c/o pain or discomfort, taken by ambulance to [Area Hospital] ER for eval. MD, RP notified of his location. Further review reflected a progress note, dated 4/9/2024, reflected that referrals had been sent to 8 facilities after the incident to attempt to relocate the resident to a facility with a specialized locked unit. Record review of Resident #1's Medical Record reflected a tapered observation schedule of the resident, beginning with 1 on 1 observation. Record review reflected that on 8/7/2024, Resident #1 was to be observed every hour by a staff member. Further review reflected Resident #1 had not had any other elopement attempts prior to this event, or since. Interview on 8/6/2024 at 1:04 PM, the DON stated that it was found during their investigation that Resident #1 had exited the facility through the door to the fenced-in patio area. The DON stated that there is a gate on the fenced-in patio area that is secured with magnetic locks, and sometime before the incident on 4/8/2024, the magnetic locks securing the gates had become misaligned due to shifting in the ground, causing the magnetic locks to fail to lock due to the lack of contact . The DON stated this was found during their investigation after the incident. The DON stated that Resident #1 went through those gates and walked next door, approximately 500 feet away, to an unlocked, abandoned mini van in the fence-line of the next-door lot. The DON stated that because she lives 2 minutes away, she was at the facility within 3 minutes of receiving the call that staff were unable to locate Resident #1. The DON stated that due to Resident #1's psych behaviors , no facilities they reached out to with specialized locked units would accept Resident #1. The DON stated that Resident #1 was sent to the emergency room to be evaluated for injury and was returned to the facility with no injury. The DON stated Resident #1 received enhanced monitoring which has slowly tapered down from one-on-one observation to checking on the resident on specific time intervals. The DON stated that residents are evaluated based on wander risk as required and as needed, and any residents who seem to be a high wander risk will be placed on a higher supervision level. Interview on 8/6/2024 at 1:20 PM, Maintenance Director stated that the magnetic locks had all been assessed after the incident with the contracted company who completes maintenance on them. Interview on 8/6/2024 at 4:18 PM, Resident #1 stated he did not remember leaving the facility or why he would have done that . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 8/8/2024 at 11:05 AM revealed CNA C on one-on-one observation with a resident who was not Resident #1. CNA C stated she was on one-on-one observation with the resident because he was wandering and exhibiting exit-seeking behaviors. CNA C stated that residents who are identified as elopement risks are watched more frequently due to the risk of elopement. A record review of an internet-based map accessed on 08/06/2024 as described by the DON revealed Resident #1 was located approximately 500 feet from the facility's patio door. The Administrator was notified on 8/7/2024 at 9:09 AM, a past non-compliance IJ situation had been identified due to the above failure. The facility implemented the following interventions. During an interview and observation on 8/6/2024 at 1:04 PM, the DON stated the facility has begun changing the security code to every door with a security code in the building every month to ensure residents do not learn the code. The DON stated that during their investigation of the event and processes in which to correct what occurred to ensure this did not occur again, the facility had an alarm installed to the patio door, implemented code lock on the patio door which required residents to ask staff to open the patio door for them, fixed the magnetic locks on the gate and ensured all magnetic locks utilized by the facility were maintained and functional. The magnetic lock functions were also changed from automatically locking after 10 seconds of contact to automatically locking after 2 seconds of contact. During the interview, and observation of the patio door being opened was conducted. Staff was seen to open the patio door for residents while an alarm sounded until the resident was outside, and the patio door was closed and locked. The DON stated that along with this, all staff (66 staff) were given in-service trainings on the elopement protocol, the door lock and code change procedures, and elopement drills were held. Record review of facility door code change logs revealed facility measures put in place for door code changes were being utilized, with weekly door lock changes happening and being recorded in a paper log to ensure all doors are changed. Record review of the facilities employee roster dated 4/9/2024 reflected 66 staff employed at the facility at the time of the incident. Record review of the facility's in-service records dated 4/9/2024 revealed 66 of 66 staff members across all departments and work shifts had signed and documented they received the trainings on elopement protocol and the new changes made after Resident #1's elopement. Interview on 8/6/2024 at 3:04 PM, LVN K stated she received training on elopement after Resident #1 eloped in April of 2024. LVN K stated the in-service covered checking doors when they hear alarms go off, doing head count, checking more frequently on Resident #1, and more general elopement items. LVN K stated she felt comfortable with the training and generally does not have any concerns related to risk of residents eloping. Interview on 8/6/2024 at 3:06 PM, MA N stated she received in-servicing on elopement on 4/9/2024 and stated that they have implemented an alarm on the patio door to ensure staff is aware when a resident is going in or out. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/6/2024 at 3:13 PM, LVN J stated the in-service they received on 4/9/2024 after the elopement covered things such as the doors at the facility, access codes, checking in on where residents are located, and ensuring elopement does not occur. LVN J stated she was comfortable with the training and felt capable of implementing the elopement policies and procedures, and those to prevent elopements. Joint interview on 8/6/2024 at 3:15 PM, [NAME] V and [NAME] T stated that they were in-serviced on elopement and how to prevent elopements from happening and the new policies on elopement. [NAME] V stated they felt comfortable with preventing elopement and that if a door alarmed they would respond to it, regardless of being kitchen staff. [NAME] T agreed. Interview on 8/6/2024 at 3:20 PM, Housekeeping Staff R stated she had worked at the facility for [AGE] years and felt very comfortable with the residents and preventing elopement. HK R stated she had no concerns with the in-service and would respond to a missing resident appropriately if necessary. Facility policy titled, Elopement Response, dated revised 01/2023, reflected, It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. The Facility Elopement Response Policy then detailed, in order, what to do if staff observe a resident attempting to leave the premises, discover a resident missing from the facility, and what to do during the search and after the search to include updating care plans, making proper notifications, and completing assessments.