STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676214	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Lake Nursing Home, LLC	200 Carla St Zapata, TX 78076

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45737 Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 5 Residents (Resident #2) reviewed for medical records accuracy, in that: Resident #2's February 2025 Monitoring Administration Records documentation was incomplete and inaccurate. Staff inaccurately documented and did not sign off on the monitoring of Resident #2's wander guard. This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment. The findings included: 1. Record review of Resident #2's face sheet, dated 02/13/25, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease (memory loss, cognitive decline, language problems, behavioral changes and difficulty with daily tasks) with late onset (typically after age 65), Anxiety disorder, unspecified (intense, excessive, and persistent worry and fear about everyday situations), and heart failure, unspecified (when the heart doesn't pump blood as well as it should). Record review of Resident #2's quarterly Minimum Data Set assessment, dated 01/09/25, revealed Resident #2 had a BIMS score of 00, indicating her cognition was severely impaired. Resident #2's MDS indicated she used a walker as her mobility device. Record review of Resident #2's physician's orders, retrieved on 02/14/25, revealed orders for 1. Wander guard placement due to high risk for elopement and wandering. with frequency of every shift and a start date of 12/23/24. Record review of Resident #2's Monitor Administration Record for February 2025 revealed 2 unsigned sections on the 6pm-6am shift on 02/09/25 and the 6am-6pm shift on 02/10/25, and RN A documented Y (yes) on 02/12/25 during the 6AM-6PM shift for the following physician orders: 1. Wander guard placement due to high risk for elopement and wandering every shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's nursing note written by the DON on 02/12/25 at 6:49pm stated Resident's wander guard found in pocket of her walker. Bracelet replaced and now in place on resident's left wrist. SN (staff nurse) to continue to monitor for wander guard placement and function. Observation and interview on 02/12/25 at 5:31 pm with RN A in the dining room revealed Resident #2 did not have her wander guard on her person and was located in her bag attached to her walker. RN A was not aware of the last time Resident #2 had her wander guard on. Observation on 02/12/25 at 6:30 pm with the DON revealed Resident #2 did not have her wander guard on her and was in the bag attached to her walker. During an interview with the DON on 02/12/25 at around 6:45 pm, she stated if Resident #2 had a behavior of removing her wander guard, and it would have to be care planned. She stated, at that time, she was not sure if it was already care planned or not. During an interview with the DON on 02/14/25 at 11:19 am, she stated after Surveyor D notified her of Resident #2's wander guard not being in place on 02/12/25, she added Resident #2's removal of the wander guard to her care plan. Record review of Resident #2's care plan, retrieved on 02/14/25 revealed Resident #2 had a focus of, I have been noted wandering. I am at risk for elopement. I have a wander guard in place for my safety. I do not like my wander guard bracelet and remove it at times. When my [SIC] staff are unable to redirect to keep my bracelet on, it is placed in my walker that is with me at all times. with an initiation date of 10/15/24 and a revision date of 02/13/25. Interventions included, My [SIC] staff redirect me when I am found trying to remove my wander guard. with an initiation date of 02/12/24 and My [SIC] staff respect my wishes of not wanting to wear my wander guard bracelet at times when they are unable to redirect me, with an initiation date of 11/16/24 and revision date of 02/13/25. During record review and interview with RN A on 02/13/25 at 5:51 pm, she stated she worked with Resident #2 on 02/12/25 during the 6am-6pm shift. RN A stated Resident #2's wander guard should be placed on her wrist. RN A stated during observation of Resident #2's wander guard on 02/12/25 during dinner in the dining room, she did not have her wander guard properly placed and was located in her bag of the walker. RN A reviewed Residents #2's monitoring administration record and stated on both of her shifts on 02/11/25 and 02/12/25, her documentation was inaccurate because she marked yes that the wander guard was in place for Resident #2 but stated she shouldn't have marked yes when it was not on her wrist. RN A stated she marked yes because Resident #2 always removed her wander guard and placed it in the walker. RN A stated they would check her bag that's attached to the walker to make sure the wander guard was in there and stated every time she walked by the door, the alarm was triggered. RN A stated it was important to ensure residents wander guards were in place to prevent them from eloping from the facility and for resident safety. RN A stated she had checked for wander guard placement every shift. RN A stated Resident #2 would remove her wander guard, and stated in response, staff would tell her not to remove it or replace it if it had been removed. RN A stated the facility policy for wander guard monitoring/supervision was to have the wander guard on at all times to prevent elopement, make sure the residents were in the facility, and know where they were depending on what alarm would ring. RN A stated, in this situation, she felt she had followed the facility policy. RN A stated she had been trained upon hire on ensuring wander guards were in place. RN A stated not checking wander guards to ensure proper placement could put residents at risk for leaving the facility, getting hurt or getting lost. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During record review and interview on 02/14/25 at 11:09 am with the DON, she stated LVN B worked with Resident #2 on 02/10/25 from 6am-6pm, LVN C worked with Resident #2 on 02/09/25 from 6pm-6am, and RN A worked with Resident #2 on 02/12/25 during 6am-6pm shift and were each responsible for documentation during their shift. The DON stated Resident #2 did have an order to check wander guard placement and stated a blank on the administration record meant that it was not checked off. The DON confirmed there were blanks on 02/09/25 on the 6pm-6am shift and 02/10/25 during the 6am-6pm shift. The DON also confirmed RN A had checked off yes on the order regarding placement of Resident #2's wander guard on 02/12/24 during her 6am-6pm shift. The DON was not sure why LVN B and C had not documented Resident #2's wander guard placement on the monitoring administration record for Resident #2. The DON was informed of an observation on 02/12/25 when RN A observed Resident #2 without her wander guard in place. The DON was shown documentation completed by RN A that reflected the wander guard was in place. The DON was unable to say if the documentation completed by RN A was inaccurate and stated that was a question for RN A. The DON stated she did not know why RN A marked the wander guard in place, and stated she did not know how RN A monitored that. The DON stated when she observed Resident #2 on 02/12/25 at 6:30pm, she did not have her wander guard on her wrist, and it was in her bag. The DON stated they did not have a specific area for the wander guard to be placed and stated it just had to be on her. The DON stated she had previously trained staff over wander guards and had previously spoken to staff about not leaving until they had finished their documentation. The DON stated herself and the ADON were responsible for monitoring the records to ensure staff had completed accurate and complete documentation. The DON added that Medical Records would sometimes help when she was uploading document, and identified something was missed. The DON did not recall facility policy related to accurate and complete documentation, and stated they did not have a policy for wander guards. The DON stated it was important to complete documentation accurately and completely because it was physician orders, and the floor nurses were ultimately responsible for carrying out those orders. The DON stated incomplete, inaccurate documentation could negatively impact the residents because their orders were in place to benefit them, and if it was being documented, it needed to be for their benefit. She stated if it was not documented, then it went undone and that would be to a resident's disadvantage. During a telephone interview on 02/14/25 on 1:51 pm with LVN B, she stated she worked with Resident #2 on 02/10/25 from 6am-6pm, and was responsible for documentation. LVN B stated Resident #2 did have an order to check wander guard placement, and stated a blank on the administration record meant that the documentation was not there. LVN B stated on 02/10/25, she did check Resident #2's wander guard placement during her shift and stated it was on her right arm, LVN B stated she was unable to recall why she did not document, and she must have missed it. LVN B stated she had previously been trained on complete and accurate documentation by the ADON or DON and different nurses during her training days. LVN B stated the DON and ADON were responsible for monitoring and the records to ensure staff had completed accurate and complete documentation. LVN B stated according to facility policy, they had to complete documentation before the end of their shift. LVN B stated, in this situation, she did follow the facility policy but did not know why she had not documented for Resident #2's wander guard placement on Resident #2's administration record. LVN B stated it was important to complete documentation accurately and completely so that they could go back and see what was done or not. She stated incomplete, inaccurate documentation didn't let them know about the residents, and could impact follow up on residents' care and health. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 02/14/25 on 2:15 pm with LVN C, she stated she worked with Resident #2 on 02/09/25 from 6pm-6am, and was responsible for documentation. LVN C stated Resident #2 did have an order to check wander guard placement, and a blank on the administration record meant that she did not check it off. LVN C stated on 02/09/25, she did check Resident #2's wander guard placement during her shift, and she checked yes it was in place because it was on her walker. LVN C stated Resident #2 had removed her wander guard 2 times that day, so LVN C left it on her walker. LVN C stated the wander guard should be placed on Resident #2's wrist and not the walker. LVN C stated she did not know why she did not document for Resident #2's wander guard placement on Resident #2's administration record. LVN C stated she had previously been trained on complete and accurate documentation by the nurse she trained under upon hire. LVN C stated the DON and ADON were responsible for monitoring the records to ensure staff had completed accurate and complete documentation. LVN C stated according to facility policy, if it wasn't documented, it wasn't done. LVN C stated, in this situation, she did not follow the facility policy because she left the documentation blank. LVN C stated it was important to complete documentation accurately and completely so that they could go back to it and check and stated incomplete, inaccurate documentation could impact resident's care. During an interview with the ADON on 02/14/25 at 4:40 pm, she stated they had trained RN A on how to use their documentation system and on leaving everything checked off, but she did not have anything in writing regarding RN A's training over documentation. During an interview with the DON on 02/14/25 at 11:19 am, she stated they did not have a wander guard policy. Record review of facility in-service dated 08/24/24 revealed the training covered documentation and was completed by LVN C. Record review of facility in-service dated 01/14/25 revealed the training covered documentation and was completed by LVN B. Record review of the facility's policy titled, Charting and Documentation with a revised date of July 2017 reflected, 3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate and 7. Documentation of procedures and treatments will include care specific details including . g. The signature and title of the individual documenting.