

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 222 Fm 1077 Bandera, TX 78003	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48753</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #1) of 3 residents reviewed for elopement risk.</p> <p>Resident #1 was found lying in the grass beside his wheelchair on the opposite side of a two-lane road after he had eloped from an exit door of the facility, resulting in a laceration to his right eye and facial bruising.</p> <p>The noncompliance was identified as PNC. The IJ began on 06/4/2024 and ended on 06/05/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place all 3 residents who used a wander guard at risk for serious injuries.</p> <p>The findings were:</p> <p>Record review of Resident #1's face sheet, undated, revealed Resident #1 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (a disease that affects the central nervous system and makes it difficult for the brain to send signals to the rest of the body) and dementia (a general term for impaired ability to remember, think, or make decisions).</p> <p>Record review of Resident #1's significant change MDS assessment, dated 05/20/2024, revealed a BIMS score of 04, indicating severe cognitive impairment.</p> <p>Record review of Resident #1's significant change MDS assessment, dated 05/20/2024, revealed Resident #1 had exhibited wandering behavior four to six days over a seven day look back time period. The MDS revealed, Resident #1 was at significant risk of getting into a potentially dangerous place (e.g., stairs, outside of the facility).</p> <p>Record review of Resident #1's June 2024 physician orders revealed an order check functionality and visualization of wander guard bracelet on LLE every shift with a start date 02/14/2023 and end date 06/05/2024. In addition, there was an order check functionality and visualization of wander guard every shift with a start date 06/05/2024. All dates and shifts in June 2024 were initialed as completed.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Record review of Resident #1's care plan revealed a care plan, initiated 03/06/2023 and revised on 06/11/2024, I am exit seeking. I am at risk for elopement and/or wandering with unsafe boundaries r/t: History of attempts to leave community or home setting unattended, poor safety awareness r/t cognitive impairment. The care plan goal, initiated on 03/06/2023 with a target date 06/11/2024, stated my safety will be maintained, and I will demonstrate a well adjusted and content demeanor with my daily routine through my next review date. The care plan interventions included: Care plan with family regarding exit seeking behaviors, dated initiated 06/05/2024; Close monitoring in place for exit seeking behaviors, date initiated 06/05/2024; Distract me from exit seeking by offering pleasant diversions, structured activities, food, conversation, television, book. I prefer the following: sitting in recliner in room, dated initiated 03/06/2023; I wear a wander guard device; confirm functioning of device and change device as indicated, date initiated 03/06/2023; Identify a pattern of exit seeking: intervene as appropriate in efforts to minimize behavior, date initiated 03/06/2023; Med review per NP and psych NP, and labs ordered, date initiated 06/06/2024; Room change closer to nurses' station, date initiated 05/06/2024.</p> <p>Record review of Resident #1's progress notes, 03/06/2024 at 7:26pm, revealed this resident attempted to elope from this facility. Resident had pushed open the emergency door exit on the 100-hall unit and set off the alarms. This nurse along with another nurse found this resident being assisted back to the building by the facility administrator. Resident did have eyes on him during the attempted elopement.</p> <p>Record review of Resident #1's progress notes, 04/13/2024 at 3:29pm, revealed resident wandering to door, causing alarm to sound. Pulled resident back and encouraged him to go to another area of the building. Resident wandered down hall 100 and caused the alarm to sound. Before intervention could take place, resident was halfway out the door. Resident was holding onto door frame and his hand had to be pried (s/p) off the door frame to bring him back into the building.</p> <p>Record review of Resident #1's progress notes, 05/05/2024 at 3:55pm, revealed resident was noted to be sitting in wheelchair on sidewalk by med nurse. Redirected resident inside without difficulty.</p> <p>Record review of document titled Nrsng: Exit Seeking Risk Tool TSC-v3, dated 05/06/2024 and signed by the DON, revealed Resident #1 had on one or more occasions attempted to exit or has exited the facility in effort to wander away and Resident #1 was physically able to exit on foot or by wheelchair.</p> <p>Record review of an in-service, dated 05/05/2024, stated the subject was checking door alarms and listed the steps to check door alarms as check which hall the alarm(s) is/are going off on, make sure that hall does not have any residents at its exit door, ensure there are no residents outside the door of the hall the alarm(s) are sounding from, visually see and count every resident that belongs on that hall and once all steps above are completed the staff may turn off the alarm. The in-service was signed by 33 employees including RN A.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Record review of the facility's PIR, dated 06/12/2024, revealed on 06/04/2024 at approximately 6:45pm during change of shift report, RN A was alerted by a family member that Resident #1 was outside lying in the grass in supine (lying on back) position next to his wheelchair. RN A assessed the resident and provided first aide and out of abundance of caution, Resident #1 was sent to the emergency room for evaluation. The investigation stated Resident #1 had previously been identified as exit seeking at times and the IDT determined that a wander guard device should be used, and Resident #1 was wearing the wander guard at the time of the incident. The investigation revealed, at approximately 6:35pm, RN A indicated she heard the door alarm sounding, she proceeded to the alarm area, did not identify anything unusual and silenced the alarm. At approximately 6:40pm-6:45pm CNA D identified Resident #1 was no longer in his room and staff immediately initiated a room search and notified RN A at approximately 6:45pm. Around 6:45pm to 6:50pm, staff was notified that Resident #1 was located outside b a visitor. Resident #1 was sent to the hospital and returned to the facility around 10:22pm with a minor laceration/skin tear to forehead and no other significant injuries identified by the ER staff. The conclusion of the PIR stated it was determined, after a thorough investigation, RN A re-set the sounding alarm prior to staff confirming that all residents were accounted for. The PIR stated RN A acknowledged prematurely resetting the sounding alarm before confirming all residents were accounted for and RN A failed to adhere to the facility's elopement response policy. As a result, RN A was terminated effective 06/12/2024.</p> <p>Record review of Resident #1's incident report, dated 06/04/2024, revealed nurses were alerted that a resident was outside and observed lying supine in the grass next to his wheelchair. 911 was called, he was assessed for injury and tried to make resident as comfortable as possible without lifting him, to wait for EMS. The incident reported stated EMS arrived at 7:00pm to transport Resident #1 to the ER and revealed Resident #1's family member, physician, DON, ADON and Administrator were notified of the incident. Injuries observed at the time of the incident were listed as skin tear on the face. Mental status revealed Resident #1 was oriented to person and listed his mobility as wheelchair bound. Predisposing physiological factors included impaired memory, lower extremity weakness and confusion. Predisposing situation factors included active exit seeker.</p> <p>Record review of facility document SNF/NF to Hospital Transfer Form dated 06/04/2024, revealed Resident #1 was sent to the hospital and listed fall as the reason for the transfer. Review of the document revealed Resident #1's family member and physician were notified of the hospital transfer.</p> <p>Record review of weatherspark.com revealed the temperature in the city in which the facility was located on 06/04/2024 at 5:54pm was 102 degrees Fahrenheit and 100 degrees Fahrenheit at 6:54pm with mostly clear skies.</p> <p>Record review of Resident #1's hospital records revealed Resident #1 had a CT scan on 06/04/2024 and the findings revealed no acute intracranial abnormality.</p> <p>Record review of Resident #1's document titled PCC Skin &amp; Wound-Total Body Skin Assessment, dated 06/04/2024 at 10:45pm, revealed Resident #1 had normal skin temperature and one new wound.</p> <p>Observation of the facility grounds, 06/19/2024 at 8:30am, revealed the facility was located along side and facing a two-lane farm to market road. Observation upon approaching the facility revealed the front door to be locked and a keypad present without an access code posted. Surveyor rang the doorbell and was let inside by the Receptionist. The front door was observed and had a delayed egress bar, keypad and a wander guard system.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Observations of the facility, 06/19/2024 at 8:47am, revealed exit doors at the end of each of the 4 hallways had a delayed egress bar, STOP alarm box in the armed position and a code alert box. Exit door alarms sounded when the surveyor pressed on the delayed egress bars at all exit doors. A framed sign by the code alert alarm box, located on the wall by the nurse's station, read When door alarm sounds and ready to clear: 1. Push 1234 on keypad 1. Push green button at nurses' station. 3. Push 1234 on the keypad again. 4. Check if red light is back on all keypads. When memory alarm sounds: 1. Push 1234. 2. Push red button on wall twice. 3. Push green button once. 4. Check if red light is back on all keypads. 5. Check outside gate and doors in memory unit.</p> <p>Observation of the facility grounds and route Resident #1 traveled to exit the facility to the location he was found, 06/19/2024 at 9:15a.m., revealed Resident #1 propelled himself approximately 100 yards from the 300 hall exit door, through the parking lot and across the road where he was found lying in the grass.</p> <p>Observation of Resident #1, 06/19/2024 at 9:20am, revealed Resident #1 sitting up in a recliner in his room with a blanket covering his legs and torso. Resident #1 was watching television and was not exhibiting any signs of pain or distress. Observation revealed an approximate one-inch laceration/skin tear above Resident #1's right eye and faded brown bruising to the right side of his right eye. A wander guard was observed on Resident #1's left ankle. Resident #1 had a walker and a transport wheelchair in his room.</p> <p>During an interview with Resident #1, 06/19/2024 at 9:20am, Resident #1 was pleasant and was able to answer simple yes or no questions. Resident #1 denied being in pain, falling or being outside at any time. When asked how he got the laceration above his eye he said I fell and hurt my eyeball but was unable to find the correct words to give a description of how he fell. Resident #1 said he used a wheelchair to move around the room and facility. Resident #1 denied any additional injuries.</p> <p>During an interview with CNA A, 06/19/2024 at 9:50am, CNA A stated she was assigned to 300 hall and had provided care to Resident #1 for over a month. CNA A revealed Resident #1 was an elopement risk, was exit seeking and wandering in the facility daily and had multiple elopement attempts prior to 06/04/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>During an interview with Resident #1's family member, 06/19/2024 at 10:52am, Resident #1's family member said she received a call from RN A around 7pm on 06/04/2024. Resident #1's family member said RN A informed her that Resident #1 got out of the facility, went across the road, fell out of his wheelchair, hit his head on the ground and was sent to the ER with a cut above his eye. Resident #1's family member stated she went up to the facility the next day, found the Administrator and told him they needed to have a meeting. Resident #1's family member said during the meeting, the Administrator told her two people driving by the facility saw Resident #1 lying by the road and one of the people went in the facility and notified the staff that Resident #1 was across the road. Resident #1's family member said the Administrator told her the facility was investigating the incident and RN A had been placed on suspension. Resident #1's family member said Resident #1 had tried to exit the facility in the past and proceeded to say when she was in the meeting with the facility staff, the Administrator told her Resident #1 was trying to get out of the facility three or four times a day and that his wander guard only works for the front door. Resident #1's family member said she was aware he was exit seeking but had no idea it was three or four times a day, that seems excessive. Resident #1's family member said she was aware Resident #1 exited the facility through a hallway exit door last month but a staff member saw him go out the door and brought him back in. Resident #1's family member said the facility had recently moved him last month to a different hall prior to the elopement on 6/4/2024 but stated she did not feel like the facility was doing enough to keep Resident #1 safe. Resident #1's family member stated the facility had not issued Resident #1 a discharge notice but had discussed Resident #1 moving to a male secured unit for safety. Resident #1's family member stated she had been touring other facilities and had found a facility she was interested in moving Resident #1 which is in a nearby town. Resident #1's family member stated, in her opinion the incident should have never happened and stated she did not think the staff were watching him appropriately. Resident #1's family member said when she went to visit Resident #1 on 06/05/2024 she observed large red and purple bruising to his cheek and right side of his eye along with a laceration above his right eye.</p> <p>During an interview with LVN A, 06/19/2024, LVN A stated Resident #1 had a history of exit seeking behavior. LVN A stated Resident #1 eloped out of the door on 100 hall on 05/05/2024 while she was passing medications. LVN A stated she heard the door alarm going off at the end of 400 hall and stated she finished giving a medication and then went to the 100-hall door and observed Resident #1 in the parking lot about 15 feet away from the facility. LVN A said she did not see him exit the 100 hall door. LVN A said she went outside and redirected him back into the facility through the front door and stated Resident #1 said he was looking for his family member. LVN A stated Resident #1 was moved to 300 halls after that incident. LVN A explained that the 300 halls exit door is not visible at the end of the hall like it is on 100 and 200 halls. The 300-hall door is around a corner by the therapy gym so the staff thought if Resident #1 could not see the door, it might prevent him from trying to exit. LVN A stated before the 06/04/2024 elopement, people's normal reaction was not to really react to the alarms.</p> <p>Record review of an undated statement, provided by the Administrator and signed by LVN A, stated On 5/5/24 [name redacted] was noted exiting the 100-hall door. This nurse was out the door in 45 seconds saw the resident at all times. Redirected back into building via front door within 5 mins.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>During an interview with the Administrator, 06/19/2024 at 3:59 p.m., The Administrator said was notified on the evening of 06/04/2024 before 8p.m., Resident #1 was found outside of the facility lying across the road in the grass and was being sent to the hospital. The Administrator said he immediately began an investigation into the incident and identified RN A silenced the sounding alarm at the nurse's station. The Administrator said RN A said she heard the alarm sounding, identified the alarm code to be Zone 6 which was labeled 300 hall exit door, looked down the hall and did not see anything unusual and silenced the alarm. The Administrator stated the expectation when a door alarm goes off is for staff to look at the alarm keypad and identify which exit door has been opened, go to that door and complete a search inside and outside of the facility and complete a resident head count before the alarm is deactivated. The Administrator stated a head count of all residents was conducted when the facility became aware of the incident. All staff received education on responding to door alarms, elopement and exit seeking prevention and abuse/neglect training. The Administrator stated Resident #1's family member and physician were notified of the incident, Resident #1 was placed on 15-minute checks when he returned to the facility, self-report was completed to HHSC, Resident #1's plan of care was updated, a care plan meeting was held on 06/05/2024 with Resident #1's family member, and an Ad Hoc QAPI meeting was held on 06/05/2024 with the Medical Director. The administrator also stated the facility completed 100% audit of all residents by completing a new exit seeking tool on each resident and updated plans of care based on the outcome of the assessments. The Administrator stated the facility began random elopement drills on each shift to validate staff competency. The Administrator revealed there were 3 residents (Resident #1, #3 and #4) who were at risk for elopement and wore wander guard bracelets.</p> <p>During an interview with RN A, 06/19/2024 at 7:12 p.m., RN A stated on the evening of 06/04/2024 she was giving report to an oncoming nurse when she heard the alarm go off. RN A said no one else knew how to respond to the alarm because they were all with the staffing agency. RN A said she looked down the hallway and did hear the door alarm from the end of the hall, so she went over to the alarm keypad and silenced the alarm. RN A said, I was going to finish my medication count and then I was going to go down to the door and check it. RN A said, about that time a family member came in from outside and said Resident #1 was outside. I called 911 and ran outside and observed him lying in the grass in a supine position on the opposite side of the road. RN A said once Resident #1 left with EMS, RN A returned to the facility and completed a head count of all the other residents. RN A stated she had received training on exit seeking residents and responding to door alarms prior to the 06/04/2024 elopement and confirmed she was terminated from her position at the facility.</p> <p>During an interview with CNA D, 06/19/2024 at 7:34 p.m., CNA D stated she was assigned to Resident #1 on the evening of 06/04/2024. CNA D said around 6:30 p.m., after dinner, CNA D placed Resident #1 in his room between his bed and the recliner, locked his wheelchair brakes, turned on the television and placed his call light within reach. CNA D said she worked for a staffing agency but was familiar with Resident #1 and had worked with him many times over the past month. CNA D said she was in another room talking to a family member for about five minutes and when she walked back by Resident #1's room, he was not there. CNA D said she went to the 300 hall exit door and did not see anyone outside and said she touched the delayed egress bar and the alarm sounded. CNA D then went to the nurse's station to tell RN A she could not find Resident #1 and at that time, a family member came in and said Resident #1 was outside. CNA D stated this all occurred in approximately 11 minutes.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>During an interview with the facility Maintenance Director, 06/20/2024 at 10:56a.m., the Maintenance Director said the door alarms were checked weekly to validate they were functioning properly. The Maintenance Director stated the last time 300 hall door was tested for functionality was 05/30/2024 and no issues were identified. The Maintenance Director stated the door alarm was triggered when a person presses on the delayed egress bar. The alarm at the door would sound for 15 seconds and then the door would open and the alarm would stop sounding. This alarm also triggers an alarm at the nurse's station that is coded by zones to identify which exit door has been opened. In addition, there is a red stop alarm on the door that is triggered when the door opens. This alarm will sound for 15 seconds. The Maintenance Director said the alarm at the nurse's station will continue to sound until the alarm is silenced or reset. The Maintenance Director stated he provided door alarm training during orientation and the training included identifying the exit door on the keypad when the alarm sounds, going to the exit door and conducting a search inside and outside of the door and completing a head count prior to deactivating the alarm.</p> <p>Record review of a facility document titled Work History Report listed a task doors, locks &amp; alarms: Corridor -Doors. The task completion was marked down on time by Maintenance Director on 05/30/2024.</p> <p>During an interview with a facility family member, 06/20/2024 at 1:20p.m., the family member stated she was leaving the facility around 6:45p.m. on the night of 06/04/2024. When the family member was pulling out of the parking lot, she saw a man lying on the grass on the opposite side of the road tangled up in his wheelchair. The family member said she stopped her car and ran to Resident #1 and got his wheelchair off him. The family member said another person passing by stopped to help so the family member ran across the street and notified the facility staff that Resident #1 was lying out by the road. The family member said approximately five people ran out to help and said, It was like 103 degrees outside that day, who know what would of happened to him if I didn't see him. The family member also said she went to the store and bought bottled water for the staff because it was so hot outside at the time of the incident.</p> <p>Record Review of a facility policy titled Elopement Response &amp; Exit Seeking Management, date implemented 2019 and date reviewed/ revised January 2023, revealed if a resident is unable to be located or the alarms have sounded, immediately initiate a search of the entire community both inside and outside the premises.</p> <p>The facility course of action prior to surveyor entrance included:</p> <p>Record review of the Administrator's PIR, dated 06/12/2024, revealed an investigation was initiated on 06/04/2024 and all required notifications were made which included the Medical Director, responsible party, and physician.</p> <p>Record review of a facility document titled [Facility] Elopement Response, initiated date 06/04/2024, revealed the following actions:</p> <p>Director of Nursing/Designee will educate current team members and new hires and agency personnel prior to working the floor regarding: missing person response and elopement/exit seeking risk and proper response to missing resident/resident elopement protocol and preventing, identifying, and reporting abuse and neglect.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Administrator/DNS/Designee conducted an elopement drill to ensure that team members understand and carry out an appropriate elopement response.</p> <p>Resident # 1 placed on close monitoring and to ensure maintain safety.</p> <p>Nursing notified MD and family representative of incident and resident status.</p> <p>The following was initiated on 06/05/2024:</p> <p>VP of Clinical Operations and VP of Operations conducted in-service training to the identified, Director of Nursing and Administrator regarding: missing person and elopement/exit seeking response. Addition education provided reviewed the process for reviewing the TXHHSC PL for reporting criteria of missing resident/elopement in order to ensure compliance with state and federal regulations: preventing, identifying and reporting abuse and neglect, facility process for identifying potential risks for elopement; implementing appropriate interventions and updating the plan of care as indicated.</p> <p>Director of Nursing/Designee will conduct an audit of all recent new admissions and readmission, reviewing the exit seeking assessment in order to identify any concerns with exit seeking or elopement risks and the IDT will review and/or will update the plan of care as indicated.</p> <p>Administrator/Social Worker/Director of Nursing/Designee will conduct staff and resident interviews to identify any concerns of exit seeking/elopement behaviors. If identified the IDT will review the plan of care and/or will update the plan of care as indicated in order to ensure it appropriately reflects potential exit seeking/elopement risk noted.</p> <p>Director of Nursing/Designee to conduct retraining for all team members as well as agency staffers (nurses/CNAs) prior to assuming next shift. DNS/Designee will ensure that all newly hired team members receive the training as part of the onboarding.</p> <p>Ad Hoc QAPI held with Administrator, Director of Nursing and Medical Director to review the concerns and plan of removal implemented.</p> <p>Admin/DNS/SW/Designee will conduct random weekly audits of 1-3 new admission and/or readmission initial care plans and comprehensive care plans in order to validate the accuracy of the care plan by ensuring identified elopement risk are noted in the plan of care and appropriate interventions are in place.</p> <p>Director of Nursing/Designee will audit and review progress notes, changes in conditions, risk management reports and the nursing 24 hr. report daily 5-7 days per week during the morning clinical meeting in order to validate appropriate follow up and necessary interventions are in place.</p> <p>Administrator/Director Nursing/Designee will conduct elopement/missing person response drill on random shifts to identify competency of TMs or to identify additional education needs. Drills will be conducted 2-4 times per month for the next 1-2 months.</p> <p>This plan will remain in place for the next 2 months and findings will be reported to the QAPI committee during monthly meeting for the next 2 months. The QAPI committee will then determine compliance or identify a need for additional training.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Record review of facility document titled Conduct and Workplace Expectation Notice revealed RN A was suspended on 06/05/2024 during the investigation and was terminated by phone from employment on 06/12/2024. The document was signed by the Administrator and DON.</p> <p>Record review of Resident #1's chart revealed an exit seeking risk tool assessment, completed 06/02/2024 at 10:30p.m., and skin assessment, completed 06/04/2024 at 10:45p.m., when Resident #1 returned from the hospital. Record review revealed Resident #1's care plan had been updated on 06/05/2024 to include a care plan meeting with Resident #1's family regarding exit seeking behaviors, close monitoring in place for exit seeking behaviors, medication review per NP and psych NP and labs as ordered.</p> <p>Record review of a facility staff roster, undated, revealed 57 employee signatures.</p> <p>Record review of an in-service titled Abuse and Neglect, dated 06/05/2024, with the facility abuse and neglect policy attached, revealed 62 employee names.</p> <p>Record Review of an in-service titled Door Alarms, dated 06/05/2024, revealed the following guidance with bullet points: Check which hall the alarm(s) is/are going off on the panel, make sure that hall does not have any residents at its exit door, ensure there are no residents outside the door of the hall the alarm(s) are sounding, visually verify and count each resident that resides on that hall and once all steps above are completed the staff may turn off the alarm. The in-service has 63 employee signatures.</p> <p>Record review of an in-service titled Elopement Response and Exit Seeking Management, dated 06/05/2024, revealed 61 employee signatures.</p> <p>Record review of an in-service titled Missing Person and Elopement/Exit Seeking Response, dated 06/05/2024 and conducted by VP of Clinical Operations and VP of Operations, was signed by the Administrator and DON. The in-service read Missing person and elopement/exit seeking response. Additional education provided reviewed the process for reviewing the TXHHSC PL for reporting criteria of missing resident/elopement in order to ensure compliance with state and federal regulations: Preventing, identifying and reporting abuse and neglect, Facility's process for identifying potential risk of elopement; implementing appropriate interventions and updating the plan of care as indicated.</p> <p>Record review of an Ad Hoc QAPI Meeting, dated 06/05/2024 at 10:15a.m., revealed 6 signatures, including the Administrator, DON and Medical Director.</p> <p>Record review of a facility document titled IDT: Care Plan Conference &amp; Advanced Care Planning Review-V4, dated 06/05/2024 at 12:45p.m., revealed a care plan meeting with Resident #1's resident representative, Administrator, DON and ADON. The care plan meeting was held to discuss Resident #1's exit seeking behavior and a potential discharge to a male memory care unit.</p> <p>Record review of 5 resident charts revealed new elopement risk assessments completed on 06/05/2024.</p> <p>Record review revealed elopement drills were conducted on 06/05/2024 at 6:15p.m., 06/06/2024 at 10:10a.m., 06/07/2024 at 5:00a.m., 06/07/2024 at 5:15p.m., 06/07/2024 at 6:15p.m., 06/08/2024 at 6p.m. - 6a.m., 06/08/2024 at 8:00 a.m., 06/09/2024 at 10:15a.m., 06/09/2024 at 6p.m. - 6a.m., 06/10/2024 at 6:10p.m., 06/10/2024 at 11:35a.m.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676233	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2024
NAME OF PROVIDER OR SUPPLIER  Bandera Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  222 Fm 1077 Bandera, TX 78003	
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>Record review of maintenance work history report revealed door locks and alarms were marked as completed on 06/04/2024, 06/13/2024 and 06/20/2024.</p> <p>Record review of Resident #3's face sheet revealed Resident #3 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think, or make decisions).</p> <p>Record review of Resident #3's quarterly MDS assessment, dated 04/15/2024, revealed Resident #3 had a BIMS of 04, indicating severe cognitive impairment. In addition, the MDS revealed Resident #3 had no exhibited wandering behavior during the 7 day look back period.</p> <p>Record review of Resident #3 June 2024 physician orders revealed Resident #3 had an order to check functionality and visualization of wander guard/exit management system through wand or alarmed door, start date 09/26/2023.</p> <p>Record review of Resident #3's exit seeking tool, dated 06/05/2024 revealed Resident #3 was wandering and exit seeking, had verbalized the need or desire to go home or to another location, had sundown syndrome (resident experiences increased confusion, occurring specifically at dusk) and was physically able to exit on foot or by wheelchair.</p> <p>Record review of Resident #3's care plan revealed Resident #3 had an exit seeking care plan, initiated 06/20/2022 and revised 09/26/2023.</p> <p>Observation of Resident #3, 06/20/2024 at 11:00a.m., revealed Resident #3 sitting in a stationary chair in her room reading a magazine. A wander guard bracelet was observed on Resident #3's left arm.</p> <p>Observation of Resident #1, 06/20/2024 at 11:08a.m., revealed Resident #1 lying in his bed watching television. Resident #1 had his call light in reach and wander guard on his left leg. Resident #1 was pleasant and did not appear to be in any pain or distress.</p> <p>Record review of Resident #4's face sheet revealed Resident #4 is an [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Dementia (a general term for impaired ability to remember, think, or make decisions).</p> <p>Record review of Resident #4's quarterly MDS assessment, dated 05/13/2024, revealed a BIMS score of 01, indicating severe cognitive impairment. In addition, the MDS revealed Resident #4 had exhibited wandering behavior 1 to 3 days in the 7 day look back period.</p> <p>Record review of Resident #4's June 2024 physician orders revealed Resident #4 had an order to check functionality and visualization of wander guard/exit management system through wand or alarmed door, start date 05/02/2024.</p> <p>Record review of Resident #4's exit seeking tool, completed 06/05/2024 revealed Resident #4 was exit seeking, had a diagnosis associated with confusion which may indicate future likelihood for wandering, had confusion, had sun [TRUNCATED]</p>		