STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676292	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luling Care Center	501 W Austin St Luling, TX 78648

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately or no later than 24 hours for one (Resident #1) of three residents reviewed for abuse and neglect. The facility failed to report to the State Agency an incident where Resident #1 eloped from the facility without staff knowledge and was found approximately an hour later after he had fallen on railroad tracks approximately one mile from the facility on 10/07/24. This failure could place residents at risk of abuse or and neglect. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, history of falling, Parkinson's disease (a movement disorder that affects the nervous system and worsens over time, cerebral infarction (stroke), unsteadiness on feet, and muscle wasting and atrophy (wasting away). Review of Resident #1's quarterly MDS assessment, dated 08/14/24, reflected a BIMS of 12, indicating a moderate cognitive impairment. Section E (Behavior) reflected the behavior of wandering was not exhibited. Review of Resident #1's quarterly care plan, reflected he was at risk for falls r/t poor safety awareness and mobility with an intervention of therapy to evaluate and treat. Review of Resident #1's most recent Fall Risk Assessment, dated 06/09/24, reflected a score of 14 (a score of 10 or higher represented a high risk for falls). Review of Resident #1's Elopement Risk Assessment, dated 12/01/23, reflected a score of 3 (a score of 5 or higher represented a high risk of elopement). Review of Resident #1's Elopement Risk Assessment, dated 10/10/24, reflected a score of 13 (a score of 5 or higher represented a high risk of elopement). (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes in his EMR, dated 10/07/24, reflected the following: [Resident #1] left facility without signing out and facility staff received a call that [Resident #1] had fell while he was away . During an interview on 10/10/24 at 2:34 PM, the CRN stated the facility found out Resident #1 was missing on 10/07/24 when EMS called to inform them, he (Resident #1) was found on the railroad tracks approximately a mile from the facility. The CRN stated the train station contacted the police who then contacted EMS. The CRN stated he was assessed with no injuries and brought back to the facility. The ADM stated he had not self-reported this incident to HHSC because Resident #1 was his own RP, he was not injured, the weather was not bad that day, and he had not missed any doses of medication. He stated he was not informed that he had fallen on the railroad tracks. The ADM stated if he would have known about that part, he would have reported it. The CRN stated (and the ADM agreed) that the definition of elopement was a resident who left the facility and was in harm's way mainly because of their cognition or could not make good decisions because of a diagnosis of dementia. The ADM stated if a resident wanted to leave, and they were their own RP, and their BIMS was high enough, then they were able to leave. The ADM stated the importance of notifying the staff they were leaving was to help them make good decisions. The ADM stated he thought Resident #1 did sign out but did not tell anyone where he was going. The ADM stated no one really knew how long had had been missing, but he could not imagine it had been more than one hour. The ADM stated a negative outcome of a resident not following their OOP protocols was that they could get very hurt. Review of the facility's Preventing Resident Abuse Policy, revised November of 2010, reflected no mention of when abuse or neglect should be self-reported to HHSC. Review of the Long-Term Care Regulation Provider Letter (PL 2024-14), dated 08/29/24, reflected the following: Do report, immediately, but no later than 24 hours after the incident occurs or is suspected, an accident that does not result in serious bodily injury but that involves any of the following: neglect, a missing resident .

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(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** 42949 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 was not missing from the facility on 10/07/24 for an unknown amount of time until EMS contacted and notified them that he was approximately .9 miles away and had fallen and found on the railroad tracks. Approximately 500 feet from the facility was a busy highway with through traffic of commercial vehicles to include semi-trucks. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 10/10/24 at 2:47 PM and an IJ template was given. While the IJ was removed on 10/11/24 at 2:38 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including type II diabetes, history of falling, Parkinson's disease (a movement disorder that affects the nervous system and worsens over time, cerebral infarction (stroke), unsteadiness on feet, and muscle wasting and atrophy (wasting away). Review of Resident #1's quarterly MDS assessment, dated 08/14/24, reflected a BIMS of 12, indicating a moderate cognitive impairment. Section E (Behavior) reflected the behavior of wandering was not exhibited. Review of Resident #1's quarterly care plan, dated 09/17/224, reflected he was at risk for falls r/t poor safety awareness and mobility with an intervention of therapy to evaluate and treat. Review of Resident #1's most recent Fall Risk Assessment, dated 06/09/24, reflected a score of 14 (a score of 10 or higher represented a high risk for falls). Review of Resident #1's Elopement Risk Assessment, dated 12/01/23, reflected a score of 3 (a score of 5 or higher represented a high risk of elopement). Review of Resident #1's Elopement Risk Assessment, dated 10/10/24, reflected a score of 13 (a score of 5 or higher represented a high risk of elopement). Review of Resident #1's progress notes in his EMR, dated 10/07/24 at 1:15 PM and documented by LVN A, reflected the following: (continued on next page)

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(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	[Resident #1] left facility without signing out and facility staff received a call that [Resident #1] had fell while he was away . During an observation and interview on 10/10/24 at 9:55 AM, revealed Resident #1 sitting on his bed with his head dropped down towards his chest. He was asked if he remembered leaving the facility a few days ago and he had a blank stare. He was asked if he had fallen and he nodded his head yes. He was asked if he had been injured and he shook his head no. When he was asked if he could explain what happened in more detail, he began drawing with his finger on his blanket. He continued to have a blank stare. During an interview on 10/10/24 at 10:06 AM, LVN B stated she was familiar with Resident #1. She stated she was not working the day he went missing but she did hear about it. She stated she did not believe he signed out or notified anyone that he was leaving. She stated he sometimes is was alert and oriented x3 (person, place, and time) but his baseline was alert and oriented x2. She stated he would absolutely not be safe to be walking out in the community by himself. She stated when residents leave OOP, they need to sign out and notify the nurse. During an interview on 10/10/24 at 10:18 AM, the RRC stated on 10/07/24 she got a call from a staff member that Resident #1 was gone and was found by the (grocery store) about a mile away. She stated she, the HR Director, and AD went to go get him. She stated when they arrived, he was sitting in his rolling walker with EMS. She stated he told them he was going to (grocery store) for some ice cream. She stated the EMT's informed them he had been found on the railroad tracks and the train station had contacted the police, who had contacted them. The EMT's informed them he was okay and they took him back to the facility. She stated when residents leave OOP, they were expected to notify their nurse and sign themselves out. She stated she was not sure if he did that as she had not followed up on that part. She stated she was not sure how long he was gone but did believe he had the ability to leave the facility unsupervised. During a telephone interview on 10/10/24 at 10:34 AM, the MD stated Resident #1 looked normal, but when you assessed him in detail - he was slow to think. He stated he was not always oriented and was often confused. He stated the streets around the facility were extremely busy and he would need supervision if he left the facility grounds. During a telephone interview on 10/10/24 at 10:51 AM, Resident #1's FM C stated she was notified that he left the faciity on [DATE]. She stated, in her opinion, he should not be able to leave the facility alone at all due him hardly being able to walk. She stated he was not safe to be unsupervised outside of the facility. She stated she last saw him in August (2024). An attempt to interview CNA D by telephone was made on 10/10/24 at 11:59 AM and 2:01 PM. A returned call was not received prior to exit. CNA D worked the morning Resident #1 left the facility (10/07/24). During a telephone interview on 10/10/24 at 2:06 PM, CNA E stated he worked the afternoon shift on 10/07/24. He stated Resident #1 may sometimes have the ability to be unsupervised if he left the facility, but he was sometimes nonverbal. He stated his cognition varied day-to-day. He stated Resident #1 would not be able to remember the rules to sign out before leaving OOP. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/10/24 at 2:27 PM, the NP stated he was notified of the incident with Resident #1 on 10/07/24. He stated he did not remember if he was told how long he had been gone from the facility. He stated he did not believe Resident #1 could be out in the community unsupervised due to both physical and cognitive reasons, but more so cognitively. He stated he was very cognitively impaired and was not there. He stated he did not believe he could understand the process of signing out even if you were to explain it to him. He stated it was a very unsafe area to be out in. NP stated he definitely believed the facility needed to come up with safer protocols should the residents want to leave the facility. During a telephone interview on 10/10/24 at 3:54 PM, LVN A stated she worked the morning of 10/07/24. She stated it was her first time working at the facility as she was an agency nurse. She stated the other scheduled nurse that day had called out to work so she was the only nurse working the shift and it was a very hectic morning. She stated she did not know around what time Resident #1 left the facility but knew he returned around 11:45 AM. LVN A stated due to it being her first time to work at the facility, she was unable to speak on Resident #1's cognitive abilities. During an interview on 10/10/24 at 2:34 PM, the CRN stated the facility found out Resident #1 was missing on 10/07/24 when EMS called to inform them, he (Resident #1) was found on the railroad tracks approximately a mile from the facility. The CRN stated the train station contacted the police who then contacted EMS. The CRN stated he was assessed with no injuries and brought back to the facility. The CRN stated (and the ADM agreed) that the definition of elopement was a resident who left the facility and was in harm's way mainly because of their cognition or could not make good decisions because of a diagnosis of dementia. The ADM stated if a resident wanted to leave, and they were their own RP, and their BIMS was high enough, then they were able to leave. The ADM stated the importance of notifying the staff they were leaving was to help them make good decisions. The ADM stated he thought Resident #1 did sign out but did not tell anyone where he was going. The ADM stated no one really knew how long he had had been missing, but he could not imagine it had been more than one hour. The ADM stated a negative outcome of a resident not following their OOP protocols was that they could get very hurt. Observation made on 10/10/24 at 8:30 AM revealed the highway approximately 500 feet from the facility was busy and saturated with cars. Review of the facility's Signing Residents Out Policy, Revised August 2006, reflected the following: 1. Each resident leaving the premises (excluding transfers/discharges) must be signed out. 2. A sign-out register is located at each nurses' station. Registers must indicate the resident's expected time of return. The ADM and CRN were notified on 10/10/24 at 2:47 PM that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided. The following POR was accepted on 10/10/24 at 5:47 PM: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 10/10/24, an abbreviated survey was initiated. 0n 10/10/24, the surveyor provided an Immediate Jeopardy notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate states jeopardy as follows: The facility failed to ensure that resident #1 was not missing from the facility for an unknown amount of time until contacted by EMS. Action: Resident #1 was immediately placed on 1:1 oversight. A full- house the interdisciplinary team completed check to validate that all residents were accounted for. The resident is on therapy and received treatment by physical therapy on 10/7/24. Start Date: 10/10/24. Completion Date: 10/10/2024 Responsible: Administrator Action: A secured facility will be located for resident #1 Start Date: 10/10/2024. Completion Date: open (1:1 oversight will remain until placement is found) Responsible: Administrator Action: All residents residing in the facility will have an updated Elopement Assessment completed and reviewed by the Administrator and the Regional Nurse for being at risk of leaving the facility. The Any nursing management nurses completed these assessments. Residents identified as being at risk as identified by a score over a 5 on the risk assessment will be evaluated further by the IDT to determine safety interventions. Residents will have an elopement assessment completed with their quarterly MDS and with any change of condition by nursing management. All scores and concerns will be reviewed by the interdisciplinary team and recommendations/interventions implemented. The regional nurse educated the administrator on processes for the residents to follow. The administrator educated the residents on the process of notifying facility staff of their desire to leave the facility for any reason. The facility staff will then sign off with the resident in the sign out book. Any concerns will be discussed with the administrator/designee before the resident will be given permission to leave the facility. The nursing management educated the facility staff on the process for residents signing out and monitoring the residents at least every hour to validate that everyone is accounted for. Any concerns will be brought to the attention of the administrator/designee. Staff, including PRN and agency not receiving the initial education will be required to receive it before starting their next assigned shift. Start Date: 10/10/2024. Completion Date: 10/11/24 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Responsible: Administrator Action: An ad hoc QAPI meeting was completed with the medical director and the interdisciplinary team to discuss this plan of removal. Start Date: 10/10/24. Completion Date: 10/10/24 Responsible: Administrator Action: Any new admissions, ongoing, will have an elopement assessment completed, and interventions implemented if indicated, upon admission. The administrator/designee will review the elopement assessment to determine concerns. Start Date: 10/10/24 Completion Date: Ongoing Completion Date Responsible: Administrator Action: The administrator initiated an Abuse and Neglect in-service with facility staff. Start Date: 10/10/24 Completion Date: 10/11/24 Responsible: Administrator The Surveyor monitored the POR on 10/11/24 as followed: Observations made on 10/11/24 from 12:38 PM - 2:31 PM revealed CNA F outside Resident #1's room while he was sleeping. She stated when he left his room, she stayed with him to ensure his safety. During an interview on 10/11/24 at 12:42 PM, the CRN stated elopement risk assessments had been completed on all residents and there was only one (excluding Resident #1) who scored as high. She stated the resident often went out on pass and was very responsible. She stated he always notified a nurse that he was going to the (grocery store) and signed himself out and in when he returned. She stated all staff, including agency staff, were being in-serviced before their shifts. She stated the ADM had spoken with residents in groups to remind them of the OOP protocols. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on 10/11/24 from 12:50 PM - 2:18 PM, staff from all shifts, including the AD, one HSK, three LVNs, and three CNAs all stated they were in-serviced prior to their shift on abuse and neglect and residents leaving the facility and resident supervision. All staff members knew that their ADM was their Abuse and Neglect Coordinator and that he should be notified any time there were any suspicions of abuse or neglect. They were all able to give examples of abuse such as verbal, physical, emotional, and psychosocial. They all stated a head count should be completed for each resident at least every hour. They all knew that if a resident wanted to leave the facility, the charge nurse needed to be notified and the resident needed to sign out. They all stated the importance for the protocols was to ensure all residents were accounted for, the staff knew where all residents were, who they went with, where they went, and an ETA for their return. The nurses stated they knew which residents were able to go OOP independently by the residents' elopement risk assessments and there was also a list in the sign-out book. All staff stated the facility was responsible for the residents' safety at all times. Review of the facility's QAPI meeting agenda, dated 10/10/24, reflected the ADM, the CRN, the RRC, the ADON, the AD, the HRD, and MD were in attendance. Review of four residents' (including Resident #1) Elopement Risk Assessments in their EMR, on 10/11/24, reflected they had all been completed on 10/10/24. Review of in-services dated 10/10/24 - 10/11/24 and conducted by the ADM, reflected all staff were in-serviced on ANE - All allegations must be reported immediately to the ADM, the Abuse Coordinator. Review of in-services, dated 10/10/24 - 10/11/24 and conducted by the CRN, reflected all staff were in-serviced on the following: It is our responsibility at (facility) to keep the residents safe from harm. The interdisciplinary team and front-line nursing staff must regularly round to identify any residents that are missing and quickly intervene. Staff will follow this process: 1. If a resident wants to leave the facility grounds, they have been instructed to notify a staff member. That staff member must sign off in the sign out book as well as the resident signing. 2. If you are not sure if a resident can sign himself out and leave the grounds, you must ask a management team member; ADM, DON, ADON, HR, before agreeing to allow them to leave the facility grounds. 3. Any concerns must be brought up to the immediate attention of the management or the nurse in charge, if management is not available. 4. Walking rounds must be done every hour to make sure that all residents are accounted for and on facility grounds. Any concerns must be acted upon immediately. Review of in-services, dated 10/10/24 and conducted by the ADM, reflected residents were in-serviced on the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any resident who leaves the facility and does not sign out and provide information such as where you are going, when you will return, and who you are going with will be placed in another facility which may be a secure unit. Staff and resident will enter the entry in the sign-out book. While the IJ was removed on 10/11/24 at 2:38 PM, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.