STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676468	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Rehabilitation and Wellness Center	11490 Gateway North Blvd. El Paso, TX 79934

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 Note: The nursing home is disputing this citation.	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** 43871 Based on observation, interview, and record review the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 10 residents reviewed for missing person. The facility failed to provide supervision to prevent accidents for Resident #1 who exited the building on 4/19/24 and was left to sleep outside overnight. This failure placed Resident #1 at risk of insect bites, a fall, and weather exposure, which could result in injuries, hospitalization , or death. The noncompliance was identified as PNC. The IJ began on 4/19/24 and ended 04/22/24. The facility had corrected the noncompliance before the survey began. Findings included: Record review of Resident #1's face sheet dated 07/09/24 revealed a [AGE] year-old male with diagnosis of Parkinson's disease, altered mental status, muscle wasting and atrophy, muscle weakness, unspecified lack of coordination, cognitive communication deficit. He did not have a history of wandering and/or exit seeking. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 11, indicating he had moderate cognitive impairment and required x1 person assist with transfers. Record review of Resident #1's elopement risk dated 02/07/24 revealed his physical capability was total dependence, he understood and verbalized acceptance of needs for nursing home, no history of attempts to leave own residence/facility, no restless or anxiety, he was a new admission, he recognized stop lights and signs, knows precautions when crossing streets, can state his name, knew location of current residence and recognized his physical needs. He was scored low for elopement risk. (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 Note: The nursing home is disputing this citation.	Record review of Resident #1's baseline care plan dated 02/08/24 revealed I am a smoker; I have been assessed to be: independent smoker with goals My desire to smoke will be honored daily and will smoke in designated area through next review date and interventions of complete smoking assessment as per facility policy, ensure I am aware of smoking times and assist if needed, ensure staff aware of my smoking desire. There was also a focus area for ADL self-care perform ance deficit with goal will improve current level of function with all ADL's through the review date and interventions of [Resident #1] requires assistance by staff to maximize independence with transferring. Record review of Resident #1's smoking assessment dated [DATE] revealed he was cognitively capable of making the decision to smoke. He was able to understand the facility smoking policy. Resident #1 was able to indicate designated smoking area verbally/physically. Resident #1 did not have any functional limitation to prevent him from smoking without assistance or supervision. Resident #1 was able to independently light his own cigarette and had adequate vision. Resident #1 did not have a history of smoking related problems that would be hazardous to self or others. He was able to verbalize understanding of the facility's smoking policy and issues related to smoking. Resident #1 did not show any physical signs that he may have a problem with smoking safely such as cigarette burn holes in clothing, burns in body, burn on Resident #1 or/in furniture . Resident #1 did not require smoking apron, cigarette holder and supervision while smoking, Record review of Resident #1's MARS dated April 2024 revealed no medications were missed between 9:27 pm to 6:52 am Last scheduled medication was administered at 8pm on 04/19/24. Record review of facility's incident report log for April 2024, revealed no incidents noted the night of 04/19/24. Record review of patio footage revealed: 4/19/24 at 09:21:01 PM door is seen being pushed (in the bistro area). 4/19/24 at 09:27:18 PM Resident #1 was seen pushing door with hands and feet and he is on a wheelchair. 4/19/24 at 09:30:17 PM Resident #1 pushed door wider with feet. The footage did not have audio. 4/19/24 at 09:34:33 PM Resident #1 made his way out from door. 4/19/24 at 09:39:51 PM Resident #1 was seen making his way down the walkway outside. 4/19/24 at 09:43:12 PM Resident #1 was last seen on video. 4/20/24 at 06:28:47 AM empty wheelchair seen by the fence in patio area, Resident #1 was not seen. 4/20/24 at 06:40 AM Resident #1's head was seen as if raising his head. 4/20/24 at 06:52:50 AM LVN E was seen walking out and walked over to wheelchair. 4/20/24 at 06:53:32 AM LVN E approached Resident #1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	4/20/24 at 06:54:50 AM RN D was seen walking out to both LVN E and Resident #1. 4/20/24 at 06:55:52 AM both nurses assisted Resident #1 to wheelchair. 4/20/24 at 06:56:26 AM LVN E, RN D and Resident #1 entered facility. Record review of nurses' station footage revealed: 04/19/24 at 09:28:43 PM CNA A seen walking by bistro looking to the bistro direction and continued walking. Refence timeline above. 4/19/24 at 09:27:18 PM Resident #1 was seen pushing door with hands and feet. He is on a wheelchair. 4/19/24 at 09:30:17 PM Resident #1 pushed door wider with feet and went outside. During an interview on 07/09/24 at 5:36 am, CNA B stated she had worked the night shift (10 pm-6 am) on 04/19/24. CNA B stated when she arrived for report at around 9:50 pm, no unusual reports were provided. CNA B stated when she did her first round around little after 10 pm, she had noticed Resident #1 was not in his room and assumed he had gone out with family. CNA B stated she did her second round around midnight and had noticed Resident #1 was not in his room and reported to LVN C whose response was OK and continued to be on her phone. CNA B stated her 3rd round at approximately 2 am, she noticed Resident #1 was not in his room and reported it again to LVN C whose response was the same. CNA B stated she did not ask any other staff for Resident #1's whereabouts due to LVN C's unbothered response to both reports. CNA B stated 2 days later she had been questioned by the Administrator in which she realized Resident #1 had been left outside the night she had reported him not being in his room. CNA B stated she had received in-services on conducting head count at beginning of shift, alternating Q2 hour checks by CNAs and LVNs for hourly rounds to be achieved, code purple (missing person), and change of shift report to be completed room by room at bedside. CNA B stated prior to the incident she had been trained to report a missing person to her supervisor and on 04/19/24 the charge nurse (LVN C) was her supervisor. During interview on 07/09/24 at 9:01 am, Resident #1 stated he remembered the incident but does not remember the date. Resident #1 stated he wanted to go smoke and did not ask anyone. He stated he went to the back patio and pushed on the door hard enough and eventually it opened. Resident #1 stated he stared at the moon and lost track of time. He stated he remembered he fell and was not hurt. Resident #1 stated he stayed on the floor of the patio and woke up on the floor the next day. Resident #1 stated he did not sustain injuries and was not cold. Resident #1 stated he was wearing pajama pants and a tshirt. Resident #1 stated he felt safe and comfortable at the facility. Resident #1 stated he was shocked that he stayed outside all night but has not been affected by it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 7/9/24 at 9:25 am, The Administrator stated during his investigation related to Resident #1's incident on Monday 04/23/24 he had asked the Maintenance Director to check the patio and nurse's station footage. The Administrator stated during his review of the nurse's station footage he identified CNA A looking in the direction of Resident #1 when attempting to exit the door and he continued walking as if he did not care. The Administrator stated he also identified LVN C had not been conducting her night rounds. The Administrator stated when he reviewed the footage in pieces as it allows, LVN C was seen either in the nurse's station on her phone or walking in and out of rooms but did not see her checking Resident #1's room. The Administrator stated he did not talk to CNA A due to him not returning call back since he no longer worked at the facility. The Administrator stated he had intended to suspend LVN C, but she had resigned as soon as she was questioned about the incident. The Administrator stated LVN C had stated she was busy attending to residents with tracheostomies because their alarm had gone off at least twice during the night shift and continued with medication administration and restocking supplies. The Administrator stated CNA B had reported and gave written statement she had voiced concern of Resident #1 not being in his room the night of 04/19/24 on 2 occasions and LVN C had dismissed her concerns with OK and continued to be on her phone. The Administrator stated he spoke to Resident #1 who had reported he was ok; he had mentioned wanting to go out to smoke and got distracted by watching the moon. The Administrator stated Resident #1 had alleged he had a fall and eventually dozed off and fell asleep on the floor. The Administrator stated no injuries were identified and Resident #1 had denied any pain/discomfort and denied being cold overnight. The Administrator stated he had referenced the weather and had been a little chilly over the weekend. The Administrator stated he referred LVN C's license to the Texas Board of Nursing due to lack of monitoring that placed Resident #1 at risk and about 60 residents that had been under her care on 04/19/24. The Administrator stated the facility-initiated in-services for conducting head count at beginning of shift, alternating Q2 hour checks by CNAs and LVNs for hourly rounds to be achieved, code purple (missing person), and change of shift report to be completed room by room at bedside. The Administrator stated someone had not reactivated the bistro door exit alarm that resulted in the alarm not activating when Resident #1 had pushed on the bistro exit door. The Administrator stated the bistro exit door had a delayed egress bar. The Administrator stated the Maintenance Director completed an in-service to ensure the exit doors are reactivated with pin pad by door that was alarming after silencing the alarm in the alarm panel. The Administrator stated a notice was placed over the alarm pad that instructed and reminded staff on the steps to check what door was alarming, how to silence the alarm, and to reset the door alarm by the keypad where the door was alarming. The Administrator stated this failure could have placed Resident #1 at risk of injury and insect bites. The Administrator stated the DON was responsible for overseeing the CNAs and charge nurses regarding bedside shift change report to ensure all residents were in their assigned room. The Administrator stated no other incidents were identified/reported for the night of 04/19/24. During an interview on 07/09/24 at 10:01 am, the DON stated she had started working at the facility after the incident with Resident #1 occurred. The DON stated she had been notified of the incident by the Administrator and had continued to monitor the at bedside change of shift report by spot checking at random. The DON stated there had not been similar incidents reported. The DON stated per Resident #1 elopement assessment he did not have elopement/ wandering behavior. The DON stated residents who had history of wandering and/or elopement had been moved to be placed in front of the nurse's station for closer monitoring. The DON stated this had been completed prior to her starting her job at the facility. The DON stated she had not received any report on missing person since she had started working at the facility. The all-door exits were delayed egress bar no issues have [NAME] identified with alarms not working. The DON stated maintenance had in-serviced staff on reactivating the alarm when coming back inside. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A call was placed on 07/09/24 at 10:31 am to CNA A, but the mailbox was full and was unable to leave a VM with information to return call. During an interview on 07/09/24 at 1:19 pm, RN D stated Resident #1 was her patient on 04/20/24 coming on the 6am-2pm shift. RN D stated when she received report from LVN C she had mentioned there had been a few room changes and she was not going to go look for them. RN D stated LVN C did the narcotic count with her and gave report with minimal information, and she left. RN D stated when she started her initial rounds, she had noticed Resident #1 was not in his room, and she alerted CNAs to assist with room checks as she continued her rounds. RN D stated when she was notified by CNAs that Resident #1 was not in any of the rooms in his assigned hallway, she initiated code purple (missing person) and LVN E had called her to notify her that Resident #1 was found outside in the patio by him and was on the floor. RN D stated she went outside to the patio and saw LVN E with Resident #1 who was on the floor. LVN E stated she had assessed him and did not find any injuries; Resident #1 had denied any pain and denied any discomfort. RN D stated LVN E and she assisted Resident #1 back to his wheelchair and took him inside to get bathed and cleaned up. RN D stated Resident #1 was monitored closely the rest of the day with no changes in condition noted. RN D stated she notified NP who gave orders for continued monitoring. RN D stated the facility-initiated in-services for conducting head count at beginning of shift, alternating Q2 hour checks by CNAs and LVNs for hourly rounds to be achieved, code purple (missing person), to ensure the alarm was reactivated and where to find instructions to activated the alarms, and change of shift report to be completed room by room at bedside. During interview on 07/09/24 at 1:32 pm, LVN C stated she had arrived around 10 pm on 4/19/24, received report from one hallway at around 10:10 pm and proceeded to get report from the second hallway she was responsible for. LVN C stated she was the nurse responsible for the hallway where Resident #1 allegedly resided. (reviewed census dated 04/19/24; Resident #1 was on one of the hallways under LVN C's care). LVN C stated after she received report she had intended to start initial rounds but was side tracked by 2 residents with tracheostomies whose alarm started going on. LVN C stated that took some time to take care of. LVN C stated she then attempted to initiate rounds but was pulled by one of the CNAs who had stated a female resident who was on the census was not in the room. LVN C stated they looked around and the female resident was located on a different hallway. LVN C stated after that was settled, she started restocking and getting her things ready for blood sugar checks. LVN C stated she had asked the CNAs if everyone was in their room and they had stated yes. LVN C stated she got busy with medication administration and her residents with tracheostomies required treatments. LVN C stated she was not notified of Resident #1 not being in his room and had not rounded on Resident #1 due to being busy with what was explained. A call was placed on 07/09/24 at 2:53 pm to CNA A, but the mailbox was full and was unable to leave a VM with information to return call. The call was not returned by date and time of exit on 07/10/24. Record review of undated Elopement/Missing Resident policy read in part To provide an organized procedure to search for an eloped or missing resident. Staff will respond in timely and organized manner to search for a resident who has eloped or is missing. A- when a resident is noted missing from the room or unit, the staff shall inform the DON of the charge nurse in his/her absence, that we have an elopement or missing resident, the residents name, and the room number. The facility completed the following corrective actions to address the non-compliance after the incident occurred but prior to the surveyor entering on 07/03/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In-services conducted and completed on 04/22/24 for: In-service on conducting head count at beginning of shift. In-service on alternating Q2 hour checks by CNAs and LVNs for hourly rounds to be achieved. (i.e., CNAs do 10pm, 12 am, 2 am, 4 am rounds and charge nurses do 11pm, 1am, 3am, 5 am rounds) In-service on code purple (missing person) In-service on change of shift report to be completed room by room at bedside. In-service on reporting to charge nurse, verifying with other staff on all hallways (CNAs and nurses) for resident accountability, and when not found in premises report to DON. In-service on ensure the adjacent door is checked and verified for closure and potential missing residents. In-service on ensure the alarm was reactivated, the alarms are to prevent elopement, checking to ensure no one has left is essential to alarm process. Record review of Resident #1's skin assessment dated [DATE] revealed no injuries noted. Record review of Resident #1's pain assessment dated [DATE] revealed no pain/distress noted and no pain voiced by Resident #1. Record review of Resident #1's SBAR dated 04/20/24 revealed no injuries noted, family member and physician were notified with no new orders provided. LVN C's license was reported to TBON (Texas Board of Nursing) on 05/02/24. LVN C's timesheet for month of April 2024 revealed 04/19/24 night shift was last day worked. CNA A's timesheet for month of April 2024 revealed 04/19/24 night shift was last day worked. Observation and interviews on 7/9/24 from 4:30 am- 6:30 am revealed CNAs B, H, I J and LVNs F, G, L, M received and understood in-services on conducting head count at beginning of shift, alternating Q2 hour checks by CNAs and LVNs for hourly rounds to be achieved, code purple (missing person), to ensure the alarm was reactivated and where to find instructions to activated the alarms, and change of shift report to be completed room by room at bedside. CNBs A, H, I J and LVNs F, G, L, M observed going in room by room for change of shift report. LVN E pushed bistro exit door and the alarm activated, CNA H and LVN G responded to the door alarm, and they pointed at the instructions over the alarm panel that read open the alarm panel, silence the alarm, light should be green. Check the surroundings with nurse in the area by that door is alarming making sure nobody gets out, then, reset the door at keypad by door alarming. Go back to panel to arm the alarm, light should be green.