

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/23/2024
NAME OF PROVIDER OR SUPPLIER Richard A. Anderson (State of Texas Veterans Land		STREET ADDRESS, CITY, STATE, ZIP CODE 14041 Cottingham Road Houston, TX 77048	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678</p> <p>Based on interview and record review the facility failed to ensure all alleged violations involving neglect were reported immediately or no later than 24 hours after the allegation was made for 2 of 7 residents (CR#1 and Resident #2) reviewed for reporting in that:</p> <p>-The facility failed to report to the State agency CR #1's fall incident with serious injury (a left distal clavicle fracture) resulting in hospitalization on [DATE].</p> <p>-The facility failed to report to the State agency Resident #2's incident of ingesting a non-food item and was transported via emergency services for hospital treatment.</p> <p>These failures could affect all residents and could result in undetected neglect and emotional distress leading to serious harm/injury.</p> <p>Findings included:</p> <p>Record review of CR #1's face sheet dated 6/20/24 revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included Parkinson's disease with dyskinesia (a disorder of the central nervous system that affects movement, often including tremors), quadriplegia, parkinsonism, cognitive communication deficit, abnormalities of gait and mobility, repeated falls, muscle wasting and atrophy, lack of coordination, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), post-traumatic stress disorder (PTSD), attention-deficit hyperactivity disorder (ADHD), right-side maxillary fracture, right-side fracture of other specified skull and facial bones, multiple fractures of ribs left-side, insomnia, osteoarthritis of hip, depression, and orthostatic hypotension (a decrease in systolic blood pressure or a decrease in diastolic blood pressure within three minutes of standing when compared with blood pressure from the sitting position).</p> <p>Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating he was cognitively intact. The MDS documented he had no potential indicators of psychosis, behaviors affecting others, or rejection of care. Per the MDS CR #1 used a wheelchair for mobility. The MDS revealed he was independent for most ADL's and needed setup or clean-up assistance with eating, showering, and shower transfers. The MDS documented CR #1 had two or more falls with no injury and two or more falls with injury. Per the MDS CR #1 was on antipsychotic and antidepressant medications. The MDS documented CR #1 received OT and PT services.</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of CR #1's care plan dated 3/22/24 revealed a focus for falls related to unsteady gait and tremors from Parkinson's disease, continued to be non-compliant with safety measure. Interventions included blood work as ordered by MD status post fall, orthostatic, take BP lying/sitting/standing x3 days, urine analysis with reflex cultures, wheelchair for long distances and walker for short distances, neuro-check, transfer to ER for evaluation, use wheelchair for safety measure, therapy to evaluate and treat as indicated, anti-tippers on wheelchair and rollator, therapy to address safety awareness while opening and closing door to exit/enter his room, encourage to use call light for staff assistance with ambulation and care needs, anti-grip high traction tape to restroom floor, remind resident to use his walker while in his room for safety precautions and staff to ensure secure/safe location to access toilet tissue within safe reach.</p> <p>Record review of CR #1's progress note created by RN A dated 3/5/2024 read, nurse was called into CR #1's room. CR #1 was in restroom and assisted back to bed, CR #1 verbalized 'when I tried to grab a tissue roll from the top of the cupboard, I lost balance and slipped and hit my head on the floor' He is alert and oriented. Skin tear seen on back of the head with mild bleeding. Pressure was applied using gauze dressing and bleeding was controlled. Skin tear seen on both elbows with mild bleeding. CR #1 is conscious. 911 was called and CR #1 was taken to VA hospital. NP, DON, and RP notified.</p> <p>Record review of incident report dated 6/21/24 revealed a fall incident for CR #1 on 3/5/24.</p> <p>Record review of the HHSC TULIP reporting system revealed no self-report for CR #1's fall incident on 3/5/24.</p> <p>Attempted interview on 6/19/24 at 3:32 p.m. to complainant was unsuccessful.</p> <p>Interview on 6/21/24 at 12:45 pm, with the DON, she said CR #1 had fallen many times. She said for every fall he had they would update his care plan. The DON asked this Surveyor if they were supposed to call the state for every fall. The DON said staff made sure Resident #1 was given extra toilet paper rolls to prevent him from getting up on his own. She said CR #1 was non-compliant and would not use his wheelchair. She said CR #1 tried to be independent but with his Parkinson's he would fall. The DON said the Administrator normally reported to the state. The DON said she received guidance form the Corporate Nurse and the Administrator for self-reporting. She said they normally reported injuries of unknown origin.</p> <p>Record review of Resident #2's face sheet dated 6/21/24 revealed an [AGE] year-old male admitted on [DATE]. His diagnoses included dementia with agitation, fatigue, difficulty in walking, lack of coordination, dysphagia (difficulty swallowing foods or liquids), cognitive communication deficit, post-traumatic stress disorder (PTSD), congestive heart failure, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), insomnia, malignant neoplasm of prostate, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), obstructive sleep apnea, and hypertension.</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating a severe cognitive impairment. The MDS documented Resident #2 had no potential indicators of psychosis, behaviors affecting others, or rejection of care; Resident #2 used a wheelchair for mobility and required one person assistance with ADLs. He was on a mechanically altered diet and antiplatelet (prevent blood clots from forming) medication. He received ST, PT, and OT services.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's care plan revised on 4/17/24 read, Focus on Resident #2 placing non-food items in mouth. Interventions: staff to ensure to keep non-food items are out of reach and not left out, room sweep of all rooms on POD to ensure all personal care items are in a secured cabinet, keep all non-food items out of resident's reach as possible, notify physician as needed, observe for signs and symptoms of aspiration. Focus: Resident #2 is at risk for aspiration pneumonia related to diagnosis of dysphagia. Interventions: diet as ordered, elevate head of bed during meals or have resident upright in chair, notify physician as needed, observe for and report signs of aspiration, thickened liquids as ordered. Focus: depression. Resident #2 at risk for mood/behavior problems. Interventions: social services as needed, observe for change in mental status, observe for signs and symptoms of depression, psyche consult as ordered.</p> <p>Record review of Resident #2's progress note created by LVN A dated 5/17/2024 CNA informed nurse that shampoo was seen on the floor in resident's room and shampoo bottle was sitting out on dresser. Veteran then was observed vomiting several times while sitting up in wheelchair a soapy like substance. Veteran unable to describe what happened. Veteran assessed immediately. 911 called for transport to ER. RP notified of transport. MD, RN supervisor, and DON notified. Veteran transferred to VA hospital.</p> <p>Interview on 6/20/24 at 2:52 p.m., with Resident #2's family member, she said on 5/17/24 there was a bottle of shampoo left on the resident's food tray and the resident drank the shampoo. She said she didn't know where the bottle of shampoo came from. She said the resident was hospitalized and was brought back to the facility same day at night. She said Resident #2 was sent back to the hospital on 5/20/24 because his health was declining. The doctor at the hospital told her Resident #2 had chemical pneumonia. She said Resident #2 came back to the facility on [DATE] and was put on a puree diet.</p> <p>Interview on 6/21/24 at 12:50 p.m. with the DON, she said they were unsure if Resident #2 drank the shampoo, but they assumed he drank the shampoo. She said Resident #2 was already throwing up and CNA C saw the shampoo bottle on the floor. She said they were unsure how long Resident #2 was vomiting. She said CNA C got Resident #2 up to get dressed for breakfast. She said CNA C went to another room to assist another resident and when he returned, he saw the shampoo bottle on the floor. The DON said CNA C took Resident #2 to the dining room area and the resident began vomiting.</p> <p>Follow-up interview on 6/23/24 at 10:00 a.m. with CNA C, he said he woke Resident #2 to get him ready for breakfast. He said he went to another resident's room to assist and when he returned Resident #2 had a white foaming substance on his mouth and his shirt that looked like shampoo and he was throwing up. He said he saw a bottle of shampoo on the floor of the resident's room, and it was not there when he left the room earlier. He said he saw the drawer by his bed open and thought Resident #2 got the shampoo out of the drawer. CNA C said he thought a family member may have brought the shampoo and put it in the drawer.</p> <p>Record review of incident report dated 6/20/24 revealed an incident under section 'Other incidents' for Resident #2 on 5/17/24 at 6:00 am.</p> <p>Record review of the HHSC TULIP reporting system revealed no self-report for Resident #2's accident on 5/17/24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on 6/23/24 at 12:40 p.m., he said the incident involving CR #1 and Resident #2 were not reported because these incidents did not meet the qualifications for reporting. He said he received guidance from Veterans Affairs (VA). He said the risk to the resident was staff would not be educated on what they were doing.</p> <p>Record review of the Abuse Reporting policy titled: Abuse Reporting dated October 2022 read in part . Procedure: 3. The facility will have a process in place to report allegation or abuse, neglect, exploitation, or mistreatment including injuries of unknow origin and misappropriation or resident property, and suspected crimes to the required agencies immediately or no later than two hours after the allegation is made if the event that cause the allegation involve abuse or result in serious bodily injury. 4. The facility will have a process in place to report allegations of abuse, neglect, exploitation, or mistreatment including injuries of unknown origin and misappropriation of resident property, and suspected crimes to the required agencies within twenty-four hours of identification if the event that cause the allegation do not involve abuse or result in serious bodily injury .</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for 2 (Resident #1 and Resident #2) of 7 residents reviewed for accidents hazards/supervision in that:</p> <p>-Resident #1 who resided in the Memory Care Unit was let out of the facility by CNA A on 2/16/24 at 6:45 pm and located by the Resident Representative around 8:30 pm on the corner of a major high traffic street corridor approximately 1/2 mile away.</p> <p>-The facility failed to prevent Resident #2 in Memory Care Unit from ingesting shampoo on 5/17/24 which resulted in emergency treatment services at the local hospital.</p> <p>An Immediate Jeopardy was identified on 06/21/24 at 3:49 pm. The Immediate Jeopardy was removed on 06/23/24 at 12:54 pm; however, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk of serious injuries or death due to lack of supervision.</p> <p>Findings included:</p> <p>1. Record review of Resident #1's face sheet dated 6/20/24 revealed a [AGE] year-old male admitted on [DATE]. His diagnoses included dementia, abnormalities of gait and mobility, lack of coordination, adjustment disorder with anxiety (a mental health condition that can occur after a significant life change), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hypertension, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), post-traumatic stress disorder (PTSD), insomnia, allergic rhinitis (an allergic response causing itchy, watery eyes, sneezing, and other similar symptoms), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe).</p> <p>Record review of Resident #1's comprehensive MDS dated [DATE] revealed a BIMS score of 3 indicating a severe cognitive impairment. The MDS documented he had no potential indicators of psychosis, behaviors affecting others, or rejection of care. Per the MDS, Resident #1 had a wandering frequency which occurred 1 to 3 days.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's care plan dated 6/4/2024 revealed a focus on at risk for difficulty in psychosocial adjustment related to admission to facility including interventions introducing self-introduction upon each visit with resident, introduce to others who may have similar interests, notify physician as needed, observe for signs and symptoms of difficulties in psychosocial adjustment; a focus on exit seeking behavior related to dementia with interventions staff educated on resident and visitor identification prior to exiting unit, wander guard placed in veteran's trumpet bag, attempt diversional activities as needed, check functionality and visualization of wander guard, check functioning of secure alarm, check placement of secure alarm, check placement per protocol, contact physician and family of attempt to leave facility, observe and monitor frequently with redirection, personal secure alarm, routine elopement risk screens.</p> <p>Record review of Resident #1's progress note created by LVN A dated 2/16/2024 at 11:02 pm read this nurse was passing evening medications and did not see resident wandering around unit as he normally does. Went to look in other resident rooms and other hallways and common areas and could not locate resident. Notified all staff that resident had not been seen recently and to start checking all rooms. When notifying staff about resident CNA explained to this nurse that when she entered unit around 6:45 pm that she thought he was a visitor and opened the door to let him off the pod from the main door. This nurse notified RN supervisor and DON. All staff in building notified of elopement. All staff began looking for veteran around facility and nearby locations. Family and Administrator also notified. While searching for resident this nurse was notified by Supervisor that family found resident at 8:30 p.m. outside of facility. Resident brought back to B-pod and was sitting in the day room. Assessed for any injuries. No c/o pain. Veteran stated that he was looking for his car when asked what happened. Fluids given to resident and consumed well. Neuro checks initiated. MD notified of elopement.</p> <p>Record review of Resident #1's progress note created by the DON, dated 2/16/24 at 11:02 pm, labeled as Late Entry read The staff provided the Veteran with a wander guard. The elopement binder was updated. An investigation was initiated, and the staff were educated on providing properly entering and exiting the memory care unit.</p> <p>Interview on 6/20/24 at 10:25 a.m., with the DON, she said the wander guard for Resident #1 was in his trumpet case. She said they tried to put the wander guard on Resident #1's wrist but he would take it off. The DON said Resident #1 carried his trumpet everywhere he went. She said on the day Resident #1 eloped from the facility; he had his trumpet and case with him .</p> <p>Observation on 6/20/24 at 11:00 a.m., revealed Resident #1 was in the memory care dining room with a group of residents. Resident #1 had a foam tube in his hands and did stretches along with the other residents. Resident #1 did not have his trumpet case with him . Resident #1 did not have a wonder guard on him.</p> <p>Attempted interview on 6/20/24 at 11:54 a.m. with Resident Representative for Resident #1 was unsuccessful.</p> <p>Interview on 6/20/24 at 2:40 p.m. with CNA A, she said on 02/16/24 at approximately 6:45 pm, she let Resident #1 out of the memory care unit because he looked like a visitor, he had a backpack with keys in his hands and told her he needed to get back out to his car. She said Resident #1 was a new resident and staff did not inform her he was new. She said it had been 3 months since the last time she worked in the memory care unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Attempted phone call on 6/20/24 at 2:45 p.m. and 6/21/24 at 12:22 p.m. to LVN A was unsuccessful.</p> <p>Observation on 6/20/24 at 4:00 p.m., CNA B located the trumpet case from Resident #1's closet to search for Resident #1's wander guard. The wander guard was tucked inside the lining of the trumpet case. ADON A entered Resident #1's room and took the trumpet case outside the memory care unit to test the wander guard. ADON A said, if a resident wanted to exit memory care, they would need to have an access card to open the doors. ADON A tested the alarms for the wander guard while standing approximately 10 feet away from the memory care entry/exit doors. The wander guard alarms proved to be working properly .</p> <p>Interview on 6/20/24 at 5:45 p.m. with the DON, she said the Resident Representative located Resident #1 on 2/16/24 at approximately 8:30 p.m. She said the facility did not call the police because the resident representative was able to locate him. She said Resident #1 had air pods on him and the Resident Representative was able to be tracked by GPS. The DON said the worst thing that could happen to a resident who eloped could result in death. The DON said the worst thing that could have happened for Resident #1 was getting lost. The DON said the protocol for when an elopement occurred was to start the search immediately, go room to room, do a count and talk with staff, and initiate parameters, such as code [NAME] on B pod. She said staff were supposed to get in their cars and search for residents. She said, the Administrator, DON, and family would need to be notified. The DON said she didn't call the police because the family knew how to locate him. The DON said the facility had never had an elopement in the past, until this incident occurred .</p> <p>2.Record review of Resident #2's face sheet dated 6/21/24 revealed an [AGE] year-old male admitted on [DATE]. His diagnoses included dementia with agitation, fatigue, difficulty in walking, lack of coordination, dysphagia (difficulty swallowing foods or liquids), cognitive communication deficit, post-traumatic stress disorder (PTSD), congestive heart failure, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), insomnia, malignant neoplasm of prostate, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), obstructive sleep apnea, and hypertension.</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating a severe cognitive impairment. The MDS documented Resident #2 had no potential indicators of psychosis, behaviors affecting others, or rejection of care; Resident #2 used a wheelchair for mobility and required one person assistance with ADLs. He was on a mechanically altered diet and antiplatelet (prevent blood clots from forming) medication. He received ST, PT, and OT services.</p> <p>Record review of Resident #2's care plan revised on 4/17/24 read, Focus on Resident #2 placing non-food items in mouth. Interventions: staff to ensure to keep non-food items are out of reach and not left out, room sweep of all rooms on POD to ensure all personal care items are in a secured cabinet, keep all non-food items out of resident's reach as possible, notify physician as needed, observe for signs and symptoms of aspiration. Focus: Resident #2 is at risk for aspiration pneumonia related to diagnosis of dysphagia. Interventions: diet as ordered, elevate head of bed during meals or have resident upright in chair, notify physician as needed, observe for and report signs of aspiration, thickened liquids as ordered. Focus: depression. Resident #2 at risk for mood/behavior problems. Interventions: social services as needed, observe for change in mental status, observe for signs and symptoms of depression, psyche consult as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's progress note created by LVN A dated 5/17/2024 at 7:05 am, CNA informed nurse that shampoo was seen on the floor in resident's room and shampoo bottle was sitting out on dresser. Veteran then was observed vomiting several times while sitting up in wheelchair a soapy like substance. Veteran unable to describe what happened. Veteran assessed immediately. 911 called for transport to ER. RP notified of transport. MD, RN supervisor, and DON notified. Veteran transferred to VA hospital .</p> <p>Interview on 6/20/24 at 2:52 p.m., with Resident #2's family member, she said on 5/17/24 there was a bottle of shampoo left on the resident's food tray and the resident drank the shampoo. She said she didn't know where the bottle of shampoo came from. She said the resident was hospitalized and was brought back to the facility same day at night. She said Resident #2 was sent back to the hospital on 5/20/24 because his health was declining. The doctor at the hospital told her Resident #2 had chemical pneumonia. She said Resident #2 came back to the facility on [DATE] and was put on a puree diet.</p> <p>Interview on 6/21/24 at 12:50 p.m. with the DON, she said they were unsure if Resident #2 drank the shampoo, but they assumed he drank the shampoo. She said Resident #2 was already throwing up and CNA C saw the shampoo bottle on the floor. She said they were unsure how long Resident #2 was vomiting. She said CNA C got Resident #2 up to get dressed for breakfast. She said CNA C went to another room to assist another resident and when he returned, he saw the shampoo bottle on the floor. The DON said CNA C took Resident #2 to the dining room area and the resident began vomiting.</p> <p>Follow-up interview on 6/23/24 at 10:00 a.m. with CNA C, he said he woke Resident #2 to get him ready for breakfast. He said he went to another resident's room to assist and when he returned Resident #2 had a white foaming substance on his mouth and his shirt that looked like shampoo and he was throwing up. He said he saw a bottle of shampoo on the floor of the resident's room, and it was not there when he left the room earlier. He said he saw the drawer by his bed open and thought Resident #2 got the shampoo out of the drawer. CNA C said he thought a family member may have brought the shampoo and put it in the drawer.</p> <p>On 6/21/24 at 3:49 p.m., the administrator was informed that an Immediate Jeopardy situation was identified due to the above failures and the IJ template was provided.</p> <p>The following Plan of Removal was submitted by the facility and accepted on 6/22/2024 at 11:49 AM:</p> <p>Immediate action:</p> <p>Upon return to facility on 2/16/2024 Resident #1 w as assessed with no injuries noted. Resident remained on 15-minute checks on secured unit until IDT felt resident was no longer at risk and/or interventions are updated and evaluated. Beginning 2/16/2024 ended 2/22/2024. Resident's Care plan was updated with new interventions wander guard added in addition to personal safety alarm. Care plan was held with resident's responsible party and IDT on 2/22/2024. Resident remains on Memory Secure Unit. Continues to have exit seeking but is redirected by staff. No further elopement incidents.</p> <p>Staff member who inadvertently let resident leave secure unit received counseling and training by DON on 2/16/2024 and 6/21/2024.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>100% of all available staff will be trained and all other staff will be trained before their next scheduled shift on elopement procedure including calling police when resident is not located in the facility. Training completed will be done by Nurse Managers on 6/20/2024 and 6/21/2024 and ongoing until all receive the training. This training includes the following.</p> <ol style="list-style-type: none"> 1. Nursing/Ancillary staff make determination that the resident is missing, and an announcement is made using facility approved protocol (CODE Brown) to alert all personnel that a search is underway. 2. DON and Administrator will be notified. 3. Resident representative notified to determine if resident is out on pass with family. 4. Each unit will send a designated person to the unit where the code was announced to gather information about the missing resident (i.e. name, description of resident). A copy of the elopement identification form will be provided from Elopement Book. 5. A person is designated as the facility person in charge of the search. They will coordinate the search to ensure that both inside and outside searches occurs. 6. Each unit or area should direct in-house staff to search room to room and all potential areas of the center: resident rooms, bathrooms, closets, laundry, under stairwells, shower rooms, under beds, utility rooms, offices, dining areas, kitchen, dayrooms, courtyards and employee lounges. 7. Facility person in charge assures all areas are being searched. 8. During open kitchen hours, the dietary staff will search the kitchen and related areas, checking the walk-in freezers/refrigerators. <ul style="list-style-type: none"> o A staff member is assigned to search the area if the kitchen is closed. 9. Two members of staff are assigned to search the outside perimeter. They should go out the front door, one goes to the left and one to the right and meet in the back, searching bushes, behind trees, around vehicles, dumpsters, outside buildings, etc. 10. Each designated person is to report back to the facility person in charge with the results of their search. 11. If resident has not been located police should be called. A copy of the elopement identification form will be provided from Elopement Book. 12. Notify Attending Physician. 13. Notify the Regional [NAME] President, Chief Clinical Officer and the Regional Clinical Consultant. 14. Upon return to the facility the resident is to be thoroughly assessed for any injuries or medical issues. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Richard A. Anderson (State of Texas Veterans Land		STREET ADDRESS, CITY, STATE, ZIP CODE 14041 Cottingham Road Houston, TX 77048	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>15. Notify search team that resident has been found.</p> <p>16. Notify Resident Representative, Administrator, DON, Physician, Police, Regional [NAME] President, Chief Clinical Officer and the Regional Clinical Consultant.</p> <p>17. Document incident and findings.</p> <p>18. Update plan of care</p> <p>An Elopement Drill will be conducted on each shift starting with evening shift on 6/20/2024 and completing with day shift 6/21/2024 by administrator and nurse managers.</p> <p>Elopement Risk book will be reviewed and updated by social workers on 6/21/2024. This book contains identification information on residents at risk for wandering. Picture of resident as well as face sheet are included. Book is available to all staff with copy at receptionist desk and on each nursing unit. 100% of all available staff will be trained and all other staff will be trained before their next scheduled shift on 6/21/2024 by facility leadership.</p> <p>All doors with the wander guard system will be checked to ensure proper function on 6/21/2024 by facility maintenance staff.</p> <p>Signage has been placed on Memory Support Doors that no one be assisted in exiting without staff members being sure they do not reside in Memory Unit on 6/20/2024.</p> <p>Upon signing into the facility visitors will receive a Visitor Badge with photo. Visitors will need to show the Visitor Badge to exit the secure unit. During shift change any residents admitted since staff member last worked are to be met by secure unit staff. Staff will be educated on this process on 6/21/2024 and ongoing until all staff are educated by Facility Leadership.</p> <p>Elopement Risk will be assessments completed on all residents. Any resident identified with elopement risk will have interventions in place. These will include but not be limited to Wander Guard, Secure Unit, Frequent checks. Care Plan will be updated. This task will be completed by Licensed Nurses and Social Workers on 6/21/2024.</p> <p>A test will be utilized upon completion of training to ensure understanding of elopement process.</p> <p>Elopement policy was reviewed and updated on 6/20/2024 by Regional Clinical Consultant. This was included in training being provide to staff on Elopement. Policy was revised to specifically address missing resident and process.</p> <p>Resident #2 returned to facility on 6/4/2024 with diagnosis of aspiration pneumonia. During hospitalization diet was downgraded to pureed with thickened liquids at recommendation of Speech Therapist. Care conference was held with wife on 6/4/2024 to discuss plan of care. Resident #2 to receive PT/OT/ST. Resident #2's room was inspected on 5/17/2024 by licensed nurses to ensure all item that are keep out of reach were in locked cabinet. The remaining rooms on memory unit were also inspected on 5/17/2024 by licensed nurses to ensure all keep out of reach items were in locked cabinets. There have been no further incidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Resident #2 currently continues PT, OT, ST. No other incidences of possible ingestion of non-food items. Care plan meeting held with wife 6/12/2024.</p> <p>An inspection was completed of all resident rooms by facility leadership on 6/21/2024 to ensure safe placement of keep out of reach items. No non-compliance noted.</p> <p>Nurse managers and social workers are reviewing all residents for any behaviors of consuming nonfood items on 6/22/2023. Any residents identified with this behavior will be care planned and have interventions to ensure they are not at risk for consuming keep out of reach items.</p> <p>100% of all available staff will be trained and all other staff will be trained before their next scheduled shift on prevention and procedure when resident consumes non-food item including calling poison control and ensuring dangerous items are not available in resident areas. Training will be provided by Nurse Managers on 6/21/2024 and 6/22/2024 and ongoing until all receive the training.</p> <p>This training includes the following.</p> <ol style="list-style-type: none"> 1. Keep out of reach items should be safely stored in cabinets. This includes any items with keep out of reach of children warning on label. 2. In Memory Unit this is a locked cabinet in each resident room to store items. 3. Any items noted out on tables or counters should be immediately stored. 4. Should it be suspected that a resident has consumed a non-food item, charge nurse and RN supervisor are to be immediately notified. 5. Poison Control will be notified. 6. Following assessment RN will contact resident's physician and carry out orders. This may include transfer to hospital for further evaluation. 7. Resident representative, DON and administrator to be notified. 8. If resident remains in facility, Poison Control directions will be followed. 9. Document incident and status of resident. 10. Update care plan. <p>Poison Control number was posted at each nurses' station on 6/22/2024.</p> <p>An electronic message call was placed to all resident representatives on 6/21/24 by administrator providing information regarding placement of keep out of reach items and directing to nurse if any questions.</p> <p>Signage was placed on each nursing unit and at entrance to memory support unit on 6/21/2024 advising that keep out of reach items need to be safely stored, and to contact nurse if any questions.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Facility Leadership will make rounds of facility daily to ensure that keep out of reach items are safely stored. This process remains as part of daily tasks indefinitely. Leadership was trained on 6/21/24 that this includes any items with keep out of reach of children warning on label.</p> <p>Medical Director was notified of IJ on 6/22/2024 at 5PM</p> <p>Facility QAPI meeting was held on 6/21/2024 at 7PM to discuss POR.</p> <p>Items not Allowed has been reviewed by Regional Clinical Consultant on 6/22/2024. This listing is provided to residents and families upon admission and reviewed with them when there is a concern. The document does include no keep out of reach of children items. Document has been posted at each nurse's station as well as on Memory Care entrance and exit.</p> <p>On 6/22/24 and 6/23/24, the surveyor confirmed the plan of removal had been implemented sufficiently to remove the Immediate Jeopardy by:</p> <p>Observation on 6/22/24 at 12:30 p.m., upon entrance into the facility, the sign-in station had an electronic device that printed a visitor badge with a photo for all visitors entering the facility.</p> <p>Observation on 6/22/24 at 12:40 p.m., the receptionist provided an elopement risk binder.</p> <p>Observation on 6/22/24 at 1:55 p.m. of the memory care doors revealed signage that read Please identify any unfamiliar person(s) with the charge nurse before allowing them to exit the memory care unit. All memory care veterans must be accompanied by staff/family when exiting the memory care unit. An additional sign posted on the memory care doors read Please ensure that all items labeled 'keep out of reach of children' are properly stored and secured. Please see the nurse if you have any questions.</p> <p>Observation and interview on 6/22/24 at 2:00 p.m., revealed Resident #2 lying in bed. He muttered we're trying to get this fixed. There were no hazardous items left out in the room or the restroom. The restroom had a keypad lock on the top cabinet and was closed shut and a keypad lock on the medicine cabinet and was closed shut.</p> <p>Observation on 6/22/24 at 2:05 p.m., revealed Resident #1 was sleeping in his bed. There were no hazardous items left out around his room or the restroom. The restroom had a keypad lock on the top cabinet and was closed shut and a keypad lock on the medicine cabinet and was closed shut . Resident #1 was not wearing a wander guard.</p> <p>Observation on 6/22/24 at 2:10 p.m. of the nurse's station in the memory care unit revealed signage that had the poison control center phone number and who to notify. Additional signage addressing items labeled keep out of reach of children were posted as well. An elopement risk binder was at the memory care's nurse's station.</p> <p>Observation on 6/22/24 at 2:53 p.m. of the nurse's station in Pod C revealed signage had the poison control center phone number and who to notify. Additional signage addressing items labeled keep out of reach of children was posted as well. An elopement risk binder was at the nurse's station for Pod C.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Observation on 6/22/24 at 2:57 p.m. of the nurse's station in Pod A revealed signage that had the poison control center phone number and who to notify. Additional signage addressing items labeled keep out of reach of children was posted as well. An elopement risk binder was at the nurse's station for Pod A.</p> <p>Observation on 6/22/24 at 3:00 p.m. of the nurse's station in Pod D revealed signage that had the poison control center phone number and who to notify. Additional signage addressing items labeled keep out of reach of children was posted as well. An elopement risk binder was at the nurse's station for Pod D.</p> <p>Interview with LVN B on 6/22/24 at 3:31 p.m., she said she had worked at the facility since 2/13/24. LVN B said if a resident cannot be found, staff would look in the resident rooms and bathrooms from the pod that the resident came from. If the resident cannot be found in the building a Code [NAME] was called over the intercom. She said two staff members would go out the front door and one staff member would go out the left and the other to the right and both staff members would meet behind the building. She said the DON, Administrator, police, and the family members would need to be notified. LVN B said non-food items were locked away in the resident's cabinet in the restroom. She said if a family member brought cleaning supplies, they would need to return the cleaning supplies to the family. She said if a resident were to put a non-food item in their mouth and ingested it, the poison control center would need to be notified along with the DON, family, and doctor. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Interview on 6/22/24 at 3:42 p.m. with CNA D, she said she had worked at the facility since 7/5/23. She said if a resident eloped from the facility, staff would search the inside of the facility by checking all the rooms, restrooms, and other areas of the facility. If the resident cannot be found inside the facility, then the search would be expanded to the outside. She said the police, DON, and family would need to be notified. She said an elopement drill was conducted today (6/22/24). CNA D said with the non-food items these need to be locked away. She said the protocol if a resident were to swallow a non-food item would be to call poison control and inform the charge nurse. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Interview on 6/22/24 at 3:48 p.m. with CNA E, she said she worked in the Memory Care unit and has worked at the facility for 2 and half years. She said if a resident eloped, she would report to the nurse's station to see who they are looking for. She would go room to room throughout the pod, then the search would be expanded throughout the facility, then outside the facility. When the search is expanded outside the facility, 2 staff members will go out the front door and go opposite ways to circle the perimeter of the building and would meet behind the building. CNA E said the non-food items needed to be locked in cabinets. If it's an item that's not supposed to be in the resident's room such as a heating pad or cleaning supplies, these types of items need to be taken to the nurse's station. She said if a resident did drink or eat a non-food item, she would need to go to the nurse's station and the charge nurse would call poison control. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 6/22/24 at 4:00 p.m. with CNA F, she said she worked in C pod and has worked at the facility since February 2024. She said if a resident eloped, an announcement would be made over the intercom Code Brown. She said the first thing she would need to do is look at the elopement book and find out who is missing. CNA F said the search would start inside the building and then expand outside. She said two staff members go outside the front door and go opposite ways to circle around the building. These two staff members would need to check all the porches at each pod and then meet up behind the building. She said she participated in the elopement drill the night before last (6/20/24). CNA F said any item that is labeled 'keep out of reach for children' would need to be locked up in the cabinet with the combination code. If a resident drank or ate a non-food item, she would notify the charge nurse and the charge nurse would notify the ADON, DON, physician, and family. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Interview on 6/22/24 at 4:12 p.m. with CNA G, she said she worked in D pod and had worked at the facility for almost a year. She said if a resident eloped, the first thing she needed to do was look at the elopement book, find out which resident eloped, and make copies of the picture of the resident that eloped to pass out to other staff. She said they would need to check inside the facility and check every door that can open, such as bathrooms, storage rooms, and kitchen. If the resident cannot be found inside the building, then the search is expanded to the outside of the building. There would be 2 staff members designated to go out the front door and go opposite directions around the building and meet up behind the building. She said with non-food items, these would need to be stored in locked cabinet and would need to make sure the cabinet is secured and shut. If a resident ate or drank a non-food item, the charge nurse and poison control would need to be notified. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Interview on 6/22/24 at 4:23 p.m. with CNA H, she said she worked in A pod and had worked at the facility since 5/7/24. She said if a resident eloped, she would need to go to the nurse's station and wait for instructions. She said the inside of the building would need to be searched first, then move to the outside of the building. She said two staff members would be designated to search outside the building. The two staff members would need to start at the front of the building and go opposite directions to meet behind the building. She said she participated in an elopement drill on 6/20/24. CNA H said items that are labeled 'keep away from children' need to be locked up. She said resident rooms need to be checked for non-food items every 2 hours and more often if time permitted. CNA H said if a resident drank or ate a non-food item, the charge nurses and poison control would need to be notified. She said she was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Interview on 6/22/24 at 4:35 p.m. with the Maintenance Director, he said he had worked at the facility for 4 years. He said the wander guard alarms were tested on [DATE] and 6/21/24. He said the wander guards were tested weekly. The Maintenance Director said the wonder guard alarms are located at the front door, at the exit door for each patio, and along the connector/hallway going down each pod. He said was in-serviced for elopement on 6/20/24 and the keep out of reach items on 6/21/24.</p> <p>Observation on 6/22/24 at 4:50 p.m., the Maintenance Director had a wander guard in his hand and walked down D pod. The wander guard alarm went off as he was walking down the hallway toward D pod. The Maintenance Director went to the patio for D pod and opened the door with the wander guard in his hand and the alarm went off.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Record review of the Elopement Risk binder identified 33 residents that were an elopement risk. These residents each had their face sheet and a picture to identify the resident.</p> <p>Record review of the Elopement Screen document dated 6/21/24 listed all residents residing at the facility were screened for elopement risk.</p> <p>Record review of the Elopement Drill documents revealed elopement drills were conducted on 6/20/24 for the 2 pm-10 pm shift and 10 pm-6 am shift. An elopement d [TRUNCATED]</p>