STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455643	A. Building B. Wing	04/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Matagorda House Healthcare Center	700 12th St Bay City, TX 77414

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36918 Based on interview and record review, the facility failed to ensure residents were provided with a 30-day notice of transfer or discharge and a copy of the notice was sent to the ombudsman of the transfer or discharge including the reasons for the move and the location to which the resident would be transferred for one resident of five residents (Resident #1) reviewed for transfer/discharge. The facility failed to provide Resident #1 with a 30-day discharge notice. The facility failed to send a copy of a notice to the Ombudsman. These failures placed residents at risk of not having access to available advocacy services, discharge/transfer options, and appeal processes. Findings include: Record review of Resident #1 's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] and discharged on [DATE]. Her diagnoses included: Alzheimer's disease (a brain disorder), dementia with behavioral disturbance (thinking and social symptoms that interferes with daily functioning), bipolar disorder (mental disorder that causes unusual shifts in mood), schizophrenia (a serious mental disorder where reality is interpreted abnormally), and suicidal ideations (self-reported thoughts of suicidal behaviors). Record review of Resident #1's quarterly MDS dated [DATE] revealed BIMS of 15 indicated intact cognition. Further review revealed resident needed one person supervision with all care with one person assistance, and occasionally incontinent of bladder. Record review of Resident #1's care plan dated [DATE] revealed the resident was on psychotropic drugs, was at risk of gait disturbance, and behavioral impairment. She also had a behavior problem of socially inappropriate, verbally abuse, wandering, sexually inappropriate behaviors. Interventions: intervene as needed to protect the right and safety of others. Further review revealed the resident was at risk for elopement related to exit seeking. Intervention: provide staff supervision for when attending an out-of-facility activity. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's elopement observation dated [DATE] revealed reason for placement related to behavior management, dementia, needed supervision, resident safely secure on unit. Staff never to leave resident unattended when out of secure unit and at risk for elopement. Rcord review of Resident #1's discharge summary dated [DATE] revealed the resident was discharged from the facility and transported by the facility to the receiving nursing facility on [DATE] at 5:15 p.m. Record review of Incident report dated [DATE] revealed on revealed Resident #1 who resides in the locked unit and required supervision was sent to the doctor's appointment on [DATE] unsupervised. She left the doctor's office and asked a stranger for a ride to a family member's home, which the stranger did. Interview on [DATE] at 11:24 a.m. the Administrator said the resident was admitted to the memory care unit because she had dementia, Alzheimer's disease, and other mental diagnoses. Upon admission, she also said the responsible party stated she was in memory care from the transferred facility. Administrator also said responsible party said the resident always says she will leave the facility and go to her family member. Interview on [DATE] at 1:29 p.m., the Social worker said Resident #1 had BIMS of 15 upon admission. She was reassessed after the elopement incident from the doctor's office, and her BIMS was still 15. SW said when the interdisciplinary committee met on [DATE], they decided that Resident #1 no longer qualified to reside in the memory care unit. They had a care plan meeting o [DATE] with the resident's responsible party, and he was notified that Resident #1 would be moved to the general public. He said he wanted the resident to continue to stay in the memory care hall because she would elope if she was left in the general public. Resident #1's responsible party was told the facility would assist in finding another place for Resident #1 to live. PR suggested that the resident be transferred back to her previous facility. When the facility was contacted, they accepted the resident, and the resident was transferred the same day of the care plan meeting. She said the facility did not provide 30 days' notice to the resident, responsible party, and ombudsman. Interview on [DATE] at 12:22 p.m., the Interim administrator said they held a care plan meeting. The Resident #1's responsible party was notified that the resident would no longer live-in memory care hall because the nurse told the DON that the resident said she would elope again when she went to the doctor's appointment and her BIMS was 15. It was against her right to stay locked up in memory. RP stated he still wants her to reside in memory care for her safety. When he realized the facility would move her to the general public or assist in finding an alternate placement, he suggested Resident#1 be transferred to the facility she came from initially. The receiving facility accepted her the same day. The resident was transferred the same day([DATE]). She said RP, resident, and ombudsman were not given a 30 days' notice because the RP suggested the facility she was transferred to. Interview on [DATE] at 12:32 p.m., DON said she LVN C told her that Resident #1 said she was going to elope when she went to the doctor's appointment on [DATE]. She called and notified the resident doctor after the nurse told her. She said the doctor said she would support the safest care for the resident. She stated the resident's responsible party was notified during the care plan meeting, and he suggested transferring the resident back to the facility she came from. She said she was not in the facility when the resident was admitted and did not know the reason why she was admitted to the memory care with BIMS of 15. She said the nurse documented what the resident said about elopement. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 12:45 p.m., LVN C said Resident #1 had told her that her long-time goal was to be discharged to the community, not eloping from the facility or when she goes out to a doctor's appointment. However, she did not tell the DON or document that the resident said she would elope. Telephone interview with Resident #1's RP on [DATE] at 2:05 p.m. he said the facility staff told him during the care plan meeting on [DATE] at 10:00 a.m. that Resident #1 would no longer reside in the memory care unit because (Resident #1) told the nurse she would elope when she went to the doctor's appointment on [DATE]. They also said she would be moved off the secure unit to the general public, and he told them that it was not safe for her and she may leave the building, and they refused for her to stay in the lock unit, which was safer for her. They stated they would make arrangements for an alternative placement to discharge her that day. Then he suggested the previous facility she came from because she was in the memory care unit. He said her mind does not work very well. She still thinks her mother, who died [AGE] years ago, is still alive, and she asks about her and the general public was not the safest place for her. He said the facility did not give him 30 days' notice, and he was not aware that he could get 30 days to help him find a better facility. Record review of facility's policy on transfer and discharge documentation dated 2001 MED - PASS, Inc. (Revised [DATE]) read . when a resident is transferred, or discharge will be documented in the medical record . policy interpretation and implementation . #1 documentation from the care planning meeting team concerning all transfers or discharge must include. As a minimum . #1b . that an appropriate notice was provided to the resident/representative .

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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** 36918 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 who was diagnosed with dementia and resided in the facility's secured unit was not dropped off without a caregiver from the facility or a family member present at the doctor's office scheduled appointment. Resident #1 eloped from the doctor's office and was later reported to be found at a family member's house. An immediate jeopardy (IJ) was identified on 04/08/2022. While IJ was removed on 04/16/2022 at 12:12 p.m. the facility remained out of compliance at a scope of isolated and severity of no actual harm with potential for more than minimum harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed facility residents with dementia and impaired cognition at risk of neglect and elopement for lack of supervision during any appointment. Findings included: Record review of Resident #1 's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included: Alzheimer's disease (a brain disorder), dementia with behavioral disturbance (thinking and social symptoms that interferes with daily functioning), bipolar disorder (mental disorder that causes unusual shifts in mood), schizophrenia (a serious mental disorder where reality is interpreted abnormally), and suicidal ideations (self-reported thoughts of suicidal behaviors). Record review of Resident #1's quarterly MDS dated [DATE] revealed BIMS of 15 indicated intact cognition. Further review revealed resident needed one person supervision with all care with one person assistance, and occasionally incontinent of bladder. Record review of Resident #1's care plan dated 12/18/21 revealed the resident was on psychotropic drugs, was at risk of gait disturbance, and behavioral impairment. She also had a behavior problem of socially inappropriate, verbally abuse, wandering, sexually inappropriate behaviors. Interventions: intervene as needed to protect the right and safety of others. Further review revealed the resident was at risk for elopement related to exit seeking. Intervention: provide staff supervision for when attending an out-of-facility activity. Record review of Resident #1's elopement observation dated 04/08/22 revealed reason for placement related to behavior management, dementia, needed supervision, resident safely secure on unit. Staff never to leave resident unattended when out of secure unit and at risk for elopement. (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	Record review of Incident report dated 03/11/22 revealed on revealed Resident #1 who resides in the locked unit and required supervision was sent to the doctor's appointment on 03/11/22 unsupervised. She left the doctor's office and asked a stranger for a ride to a family member's home, which the stranger did. Record review of Resident #1's departmental notes dated 3/2/22 documented by LVN B (agency nurse) read in part . responsible party was notified that Resident #1 had a doctor's appointment on 3/11/22 at 10:00 a.m. Interview on 3/30/2022 at 12:25 p.m. with LVN A she said on the day (03/11//22) of Resident #1's doctor's appointment the doctor's office called and said the resident refused to be seen, they rescheduled the appointment, and the resident left the office. She said the resident went outside and asked strangers (a couple) to drop her off at her sister's house, and the wife told the husband to go and drop her off, which he did. The resident's sister called the facility and said the resident was at her house. Interview on 3/30/22 at 11:24 a.m., the Administrator said Resident #1 had an appointment with a gynecologist. Her family member was notified on 3/2/22 when the appointment was made for 3/11/22 at 10:00 a.m., but the family member was frustrated and upset because the nurses did not remind her to be at the doctor's office on the day of the appointment. The Administrator said the nurse should have called and notified the responsible party and ensured she would be at the doctor's office before the resident was sent out. She also said the driver should have made sure the family member was at the doctor's office before she left the resident at the doctor's instead of dropping her off at the entrance door of the building. She said the resident refused to see the doctor and left the office. When she came outside, she asked a couple to give her a ride to her sister's house, and the husband gave her a ride to her sister's house. She said this negligence could have caused harm to the resident. The facility had two opportunities to prevent what happened, and both staff failed to protect the resident who had impaired memory. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/30/22 at a12:10 p.m., with the van driver she said when she took Resident #1 to her appointment, she stopped the van and assisted the resident out of the truck, and the resident walked into the building by herself. She said she did not know that the resident's family was not going to be at the doctor's office because the nurse did not tell her about it. She said she did not walk her into the doctor's office because she had another resident in the van that was going to another appointment. The van driver said she was the one who checks the appointment calendar every day, and when residents are ready for their appointment, the nurse will let her know, and the aide or she would escort the resident to the van. Then she will drop the resident for the appointment and come back later to pick the resident up when the doctor's office calls the facility. She said it was the nurse's responsibility to notify the resident's family that the resident was about to leave for an appointment and to meet the resident at the doctor's office. The van driver said if the resident could stay by herself, she would walk the resident into the doctor's office and leave. If the resident could not be left by herself, she would remain with the resident until the family comes or stay with the resident throughout her visit and take the resident back to the facility. She said the nurse would tell her if the resident needed supervision at the doctor's office or not. She said, to her understanding, Resident #1 was able to wait by herself because that was what she was told, but she could not remember who told her. She said it was a miscommunication because she would have walked her to the doctor's office and made sure her sister was in the doctor's office. If she was not there, she would have taken the resident and asked the doctor's office to call the facility and reschedule her appointment. The driver said this mistake put the resident at risk for harm or even death. Interview on 3/30/2022 at 12:25 p.m. with LVN A, she said she was not the one that made the appointment for Resident #1, but she was the nurse who sent Resident #1 to her doctor's appointment. She said when an appointment is made, it is put on the log for the driver, and the responsible party is notified. If the resident's family wants to be at the appointment, it will be documented. She said there was nothing written on the log that Resident #1's family member wanted to go. She said if it were documented, she would have called the responsible party and notified that the resident was about to be leaving the facility and for her to meet the resident at the doctor's office. She said she was under the impression that the driver would stay with the resident because most places she worked do not leave residents by themselves. She said they now have a new rule after the incident that the driver must have somebody to stay with the resident. They had an in-service on transportation of residents from the Memory Care Unit must be accompanied by staff. She said the mistake of not notifying the responsible party and the driver, who did not wait with the resident put the resident in harm's way (resident could get physically hurt, kill or missing). She said she had not had any in-service on transferring and monitoring the resident on doctor's visits. LVN A said the Administrator said Resident # 1 was in memory care because she has diagnoses of memory problem and mental problems and she was under supervision when she goes outside to smoke or go to the courtyard. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/30/21 at 2:14 p.m., the DON said Resident #1's doctor's office called on 03/11/22 at 10:15 a.m. , because the resident refused care and walked out of the office. The resident's family member called at 11:00 a.m., and said the resident was dropped off at her house by a stranger. The DON said the nurse should have called the responsible party after she made an appointment for Resident #1's doctor's visit and made sure a family member would be at the doctor's and document it on the resident's progress note. The nurse also puts the appointment on the 24-hour report until the resident goes to the appointment. Then call a day before the appointment and make sure they have somebody to meet the resident at the doctor's office. They also have a staff to stay with the resident if the family cannot come to the appointment. She said there was negligence in that the nurse who made the appointment did not document if the responsible party would be at the doctor's office, and the sending nurse did not call the responsible party and notify her that the resident was going to the doctor's office and remind her to be at the office. At the same time, the driver did not walk a resident from the memory care unit into the doctor's office and did not stay with her. She said all of these placed the resident in harm's way, which could have cost her life. She said she knew that the facility would be cited. She said she had not in-serviced the staff on elopement before the incident but had one after the incident. she also said whenever a resident goes out for appointment a CNA would accompany and supervise the resident. During an observation and interview on 3/30/22 at 4:30 p.m. Resident #1 said she became sick (back and waist pain) at the doctor's office, and she told the doctor's office to call the facility. They called, and the facility did not answer. Resident #1 said the doctor's office called again while she was still there and made her another appointment for 4/18/22, and they told the facility to come and pick her up, but still, the driver did not come, and that was when she left the office because she was in pain and could not wait anymore for the driver. She said she was tired of waiting, so she left and asked the people she met outside to take her to her sister's house. She said she had not met the couple before, but they were nice to her. Interview on 3/30/22 at 4:36 p.m., the van driver said the doctor's office did call her to pick up Resident #1. She said she found out the resident left the doctor's office, and she went back to the facility. Interview on 3/30/22 at 5:21 p.m. the Administrator said the facility does not have a policy on monitoring residents when they are out of the facility or a transportation policy. She said the transportation calendar and the 24-hour reports are shredded every day after use, and it does not matter anyway because the negligence did occur. She knew the facility would be cited because it is what it is. Record review of facility's policy on safety and supervision dated 2001MED - PASS, Inc. (Revised December 2007) read . our facility strives to make the environment as free from accident hazards as possible . resident safety and supervision and assistance to prevent accidents are facility wide priorities . On 04/08/2022 at 5:24 p.m. the facility Administrator and DON were notified that immediate jeopardy was identified due to above findings. IJ template was provided at this time and plan of removal was requested. The facility's plan of removal was accepted after several revisions on 04/12/2022. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The plan of removal reads as follows: 3/30/22 Physical head to toe assessment was completed upon Resident #1 returning to facility by the DON with no findings of harm. In-services are completed immediately regarding elopement, patient safety, abuse, and neglect by the nursing department with all staff including transportation CNA. The family and physician were notified, and the self-report completed and submitted to HHSC. 4/8/22 6pm. Completed BIMS assessments and elopement assessments on Resident #1 by the social services director and MDS nurse. All other residents were assessed for elopement, BIMS, and diagnosis for appropriate placement as needed by the Social Services Director and MDS nurse. Notification made to Medical Director, of Immediate Jeopardy on April 8, 2022, 5:58 p.m. 4/8/22 6pm. In-services were conducted by Administrator with Nurses, CNAs, and transportation aid including any direct care staff, regarding elopement risk-elopement policy, resident safety and supervision, resident rights-exercise of rights, dementia- resident off of memory care unit and Customer Service- policy and procedure for answering phones. 4/8/22 Quality Assurance Assessment Meeting conducted with action plan developed. This occurred on April 7, 2022. The interdisciplinary Team consists of Administrator, DON, Human Resources, ADON, DOR., Marketing, MDS, Social Services, Dietary Manager, Colonial Area Director, Medical Director, and Asst. Medical Director. 4/9/22 Management team was in the building to ensure all staff were in serviced prior to beginning their shift. DON monitored 24-hour reports to ensure no incidents occurred, no appointments were made for residents and no residents were out of the facility without proper documentation according to the new policy and procedure for safety and supervision of residents, and scheduling resident appointments. The social worker completed BIMS on all residents. MDS completed all elopement risk assessments to ensure resident safety was addressed throughout the facility. We continued in-service follow-up on answering phones timely and customer service. 4/10/22 Management team was in the building for ongoing education of new procedures for appointments, elopement risks, transportation, patient safety, resident rights, dementia, and customer service. The DON performed return demonstrations on answering the phones timely, customer service and continued training on policy and procedure including documentation on residents being outside of the facility. Facilities Plan to ensure compliance quickly: Social Worker or designee will schedule appointments outside of the facility. The family will be notified of the appointments. If the family is not in attendance on arrival, staff members will not leave the resident unattended unless cognitively intact. Social Services/designee will assess resident cognitive status and elopement risk quarterly and with any change of condition by verifying that the resident is alert and oriented to person, place, time, and situation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As Social Services/designee makes appointments the elopement risk and BIMs score will be placed on the transportation appointment book as well as the 24-hour report as, so ALL staff is aware of needs of resident. The appointment book will be kept at the nurse's station for any after hour calls/ emergency appointments. The nurses have BIMs/elopement assessments available at the nurse's station and will be added to Matrix as soon as available. This will be discussed in morning meeting for the current day as well as the upcoming day. The DON or designee will discuss upcoming appointments as well as be reviewed by the administrator. Family members will be reminded of appointments by the social worker, if family is not available another staff will be attending, and resident will not be left alone. The director of nursing will be responsible for monitoring the 24-hour report to ensure that all appointments have staff that are aware of needs of specific residents. Beginning on 04/08/2022. The Activity Director will have resident council meeting 04/11/2022 to assess if residents have any concerns during facility assisted transports and ensure residents understand who to voice concerns to. No Staff will be allowed to come back to work until after in servicing is complete. Surveyor monitored the plan of removal for effectiveness as follows: Record review of facility resident audits, assessment, cognitive status, and elopement assessment, revealed all the residents in the facility were assessed and the residents at elopement risk were placed on the elopement binder and they have to be accompanied to out of facility appointments The binders were placed at the nursing stations. Record review of facility's staff training log revealed the following trainings were documented as provided to staff: procedure for making appointments, notifying responsible parties of appointments procedure timely and ascertaining who will accompany residents, resident sign in and out log, telephone etiquette, elopement, resident rights, abuse/neglect, van driver policy and procedure training, safety and supervision, and memory care resident supervision. On 04/13/2022, four nurses (LVNs) were interviewed between 10am and 3:00pm on above trainings. Two-night staff (CNAs) were interviewed between 11:00pm and 11:45pm. All interviewed staff expressed understanding of trainings provided above. On 04/13/2022 at 12:30 p.m., the facility Van Driver was interview on the facility's new procedure for resident appointments. She expressed understanding of plan of removal trainings provided to her. On 4/14/2022 between 9:30am and 11:00am, three nurses (LVNs) were interviewed on the facility's new procedure for resident appointments. All staff interviewed expressed adequate understanding of plan of removal trainings provided to them. On 4/14/2022 at 10:43 a.m., interim Administrator said all staff were in-serviced on the plan of removal and facility's new system. DON will monitor future appointments. Interim Administrator will oversee the plan of removal completion and implementation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/14/2022 at 11:54 a.m., the DON was interviewed on the plan of removal trainings provided to staff. She said she monitored the 24-hour reports for resident scheduled appointments and checks nurse calendars to confirm. The DON said she also checks the Van Driver's appointment binder daily and meets with the Bus Driver to go over daily assignments. On 04/15/2022, MDS, ADON (LVNs) and social worker were interviewed between 12:21pm and 1:10 pm on above trainings. All interviewed staff expressed understanding of trainings provided above. On 04/16/2022 at 12:12 p.m. the interim Administrator was notified that Immediate jeopardy was removed. However, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimum harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the of the corrective systems.