STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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	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** 42158 Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent elopement for 1 (Resident #1) of 5 residents reviewed for supervision. The facility did not implement interventions to prevent Resident #1 from eloping from the facility. Resident #1 exited the facility undetected and was missing 2.5 hours before the facility initiated a search and located Resident#1 two miles from the facility. This failure resulted in an identification of a past non-compliance Immediate Jeopardy at 1:00 p.m. on 10/07/22. The noncompliance was identified as PNC. The IJ began on 08/20/22 and ended on 08/24/22. The facility had corrected the noncompliance before the survey began. This failure could place the residents with exit seeking behaviors at risk for injury or death. Findings included: Record review of Resident #1's face sheet, dated 12/22/21, revealed he was admitted on [DATE] with medical diagnoses of dementia, depression, mood disorder, insomnia, malnutrition, diabetes, high cholesterol, obesity, communication deficit, muscle wasting, abnormalities of gait and mobility, and lack of coordination. Record review of Resident #1's MDS assessment revealed his BIMS score was 5, indicative of severe cognitive impairment, and he was ambulatory. Record review of Resident #1's care plan, created on 12/31/21 (revised 08/20/22), indicated: Resident #1 had been evaluated as a wandering risk related to decreased safety awareness, confusion, wandering behaviors and had been placed in the secure unit for his safety. Interventions documented: 08/20/22 Elopement - call performed, complete blood count, comprehensive metabolic panel, in-service with staff for 3 days, frequent rounds done with the resident, and signs placed on all exit doors to not allow the residents to leave the facility for safety. Check location frequently. Encourage resident to participate in activities of preference. (continued on next page)

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
	675494	A. Building B. Wing	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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	Record review of Resident #1's care plan, dated 08/20/22, documented focus of Resident #1 eloped from the secure unit on 08/20/22 - Upon safe return to the facility, he did not exhibit any negative effects, and had no signs or symptoms of dehydration, heat exhaustion, or fatigue. On 08/23/22, daily monitoring revealed no abnormalities noted during 72 hours post incident. Interventions included: assess/record/report to MD risk factors for potential elopement such as wander, consistently communicate with all staff of Resident #1's elopement behaviors so they too can observe and redirect. Staff were to check for Resident #1's location frequently to ensure he was secure in his community. Record review of Resident #1's Elopement Risk Assessment/ Wander Data Collection completed on 12/22/21 indicated that Resident #1 was cognitively impaired with poor decision-making skills, wandered at home or in the previous living settings, and at high risk for wandering. Record review of Resident #1's Elopement Risk Assessment/ Wander Data Collection completed on 08/20/22 indicated that Resident #1 was cognitively impaired with poor decision-making skills, wandered at home or in the previous living settings, and at high risk for wandering. Record review of a progress note, documented by LVN A, on 08/20/22 at 7:42 PM documented Resident eloped from the facility staff members were searching inside the facility, managers were searching outside the facility resident was found by the maintenance Director. Responsible Party was notified Head to toe assessment was done no injuries were noted. lips moist, good skin turgor. Vitals Blood pressure 130/64, respirations 18, Pulse 85, temperature 97.9 degrees Fahrenheit, Oxygen at 98% at room air. Resident was showered and offered his supper. Record review of the facility's incident report for Resident #1's elopement, dated 08/20/22, documented: writer [LVN A] was in the dining room with the residents while the [CNA B] was passing out the hall trays and she asked writer where [Resident #1] was because he was not in his room. Writer [LVN A] went to search for resident in his bathroom, closet and asked [CNA B] to help account for the residents. Another resident in the unit was having a birthday party and the family of that resident was not aware that this resident resided in the secure unit and allowed [Resident #1] out of the unit. Elopement was called and staff searched the building. Managers searched outside of the facility and resident was found by Maintenance Director. [Resident #1] informed staff that he left to collect cans, denies pain with no signs or symptoms of pain noted. No dehydration signs or symptoms. An interview with the DON and ADM on 09/07/22 at 3:04 pm revealed there had been a large gathering for one of the other residents and family in the lobby on 08/20/22 in the afternoon, and there were a lot of people going in and out the front doors, as well as the memory care unit. So they speculated Resident #1 slipped out of the secured unit with one of them. They explained this resident had a history of wandering. They said the facility did not use wander guards and the only monitoring, besides physically watching them, was the alarms on the doors that were activated by the push bar that had to be pressed for the door to open. They said an elopement risk assessment was done at admission on every resident and those at risk would have it care-planned. They ADM revealed residents should be checked by staff at least every two hours and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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	An interview with the MS on 09/08/22 at 12:00 p.m. revealed he received an alert on his phone around 5 pm on 8/20/22 about an elopement at the facility and that the resident had already been missing for 2-3 hours. He said he arrived at the facility around 5:15 pm and immediately drove through the neighborhood around the facility where he found Resident #1 sitting on a bench in front of a saddle shop around 5:35 pm. He described the shop as being a little over 2 miles from the facility and it probably would have taken Resident #1 a couple of hours to walk that far. He said Resident #1 would have had to cross multiple streets and intersections, including a highway, to get to the saddle shop. He said they (the facility) got lucky nothing happened to Resident #1. He said when he found Resident #1, he was a little out of breath and hot, but said he was ok. He also had an old-looking plastic bag he had collected 4 empty beer cans in. Resident #1 told the MS that he was collecting cans to raise money for cigarettes. He said Resident #1 was dressed in black sweatpants, a long-sleeved western shirt, a long-sleeved black hoodie with the hood up, sneakers, and a ball cap. The MS said Resident #1 told him he was going home. He said he waited for the AD to arrive, and she took Resident #1 back to the facility in her vehicle. He said he personally put keys (10 in total) for the door alarms on each of the 4 charge nurse key rings, administration had one, and housekeeping had 5. He said he did not know how many keys were left of the 10, but he knew housekeeping had one and that was who turned off the alarm that day. He said another resident from the memory care had a party outside the memory care unit, there was a lot of in & out, and Resident #1 must have followed someone out of the locked unit. An interview with LVN A on 09/08/22 at 3:00 pm revealed she was the nurse on the secure unit during the incident on 8/20/22. She said she saw Resident #1 go into his room at 2:30 pm. She said RN A mentioned she saw someone in the parking lot that matched Resident #1's description at 2:45 pm but by the time they looked out into the parking lot, there was no one in sight. She said a room-to-room check and headcount wasn't initiated until around 5:00 PM when food trays were being passed and she discovered Resident #1 was missing. She said she did not know why a headcount was not done sooner. At 5:20 pm, she announced an elopement alert (code white) over the intercom. She said the MS found the resident, and the AD returned him at 5:36 pm via her vehicle. She said she assessed Resident #1 and found no distress and normal vital signs. She said he was bathed and offered supper. She said she knew Resident #1 was at risk for elopement. She said that was one of the reasons why he was in the secured unit. She said they get training on it (elopement) every year. She could not say why Resident #1 was not being monitored more closely. She revealed residents were to be checked on every 2 hours and as needed, but Resident #1 had not been seen since 2:30 pm. She stated, it was important to monitor residents in the secured unit more often to prevent elopement and to make sure they are safe. An interview with CNA B on 09/08/22 at 3:20 pm revealed she was the CNA on the secure unit during the incident on 08/20/22. She said she saw Resident #1 in his room on the secured unit at 2:30 pm. She said she didn't see him again, as she was assisting other residents in the living room of the secured unit until around 4 pm. She said she knew he was at risk for elopement because she worked in the secured unit frequently and it's documented in his care plan. She said they got trained on it (elopement) every year and recently, right after the incident on 8/20/22. She could not say why she was not monitoring Resident #1 more closely. She stated it was important to monitor the residents in the secure unit at least every 2 hours and prn, because they are confused and could leave the facility like Resident #1 did. She revealed Resident #1 is alert and likes his privacy and can get agitated at times when bothered during naps or when he does not want to be bothered. So they will give him time to himself, but they are checking on him more often. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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	An interview with RN A on 09/21/22 at 11:28 AM revealed she was working the day of 08/20/22 as an RN supervisor for the facility. She revealed she works as RN supervisor during the weekend and was not familiar with all the residents in the facility. She stated, around 2:45 PM, the alarm went off, she went to the door that was alarming and looked out the windows and noted a man walking with a mask through the parking lot but there are people who use the parking lot to walk to the apartments in the back of the facility, and she didn't recognize the man. She went to the locked unit to tell the staff about the man walking outside of the facility. LVN A and RN A went to look out the windows but didn't see anyone during that time. She stated, no one knew Resident #1 was not in the secured unit until LVN A alerted her around 5:15 PM. She stated, LVN A called elopement and told staff Resident #1 was missing and that it was probably the resident who she saw outside of the facility. Record review of the facility in-service dated 08/20/22 documented: Elopement topic. -When a door alarm sounds, staff shall respond immediately and determine the cause of the alarm. - Staff member responding to the alarm shall check the outside of the building to determine if a resident has left the building. -If no apparent cause is determined for the alarm, the charge nurse shall immediately initiate an accounting of the whereabouts of all the residents at risk for elopement. Observation of the secured unit on 09/21/22 revealed the exit and entrance doors had signs stating, Please make sure doors close behind you when entering. And Dear Families/Visitors, please exercise caution when exiting our facility to ensure that our residents do not leave behind you. Record review of the facility's Wanderer Management, Monitoring System and Resident Elopement protocol, dated 10/08/20, documented: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible. -Record review revealed on 08/20/22, One to one education provided to staff working during the time of incident. and Disciplinary write up for RN A about response to door alarms. -Record review and observation on 10/07/22 revealed on 08/20/22, POD checked all doors and alarms of the facility were working properly. -Record review revealed all staff working were educated and in-serviced on 8/20/22 for Door Alarms, how to identify residents at risk for elopement, how to supervise, monitor, and redirect residents, Elopement, when a resident is found, post elopement, and an elopement book. -Observation and record review revealed on 8/20/22 Signs posted at the entrance and exit of the secured unit stating, please make sure doors close behind you when entering and please exercise caution when exiting our facility to ensure that our residents do not leave behind you. - Record review of updated care plan dated 8/20/22 documented: I have been evaluated as a wandering risk related to specify: (decreased safety awareness, confusion, wandering behavior, and has been placed in the secure unit for his safety) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675494	A. Building B. Wing	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lone Star Ranch Rehabilitation and Healthcare Cent	316 General Cavazos Blvd Kingsville, TX 78363

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	Interventions included: Check my location frequently, encourage me to participate in activities of my preference, engage me in diversional activities when indicated, observe me for signs and symptoms of agitation, pacing, repetitive verbalizations of wanting to leave/go home, restlessness, report increased behaviors to nurses for further interventions, provide me with re-orientation as needed, resident will be accounted for during functions within the unit. - Record review of Resident #1's Elopement Risk Assessment/ Wander Data Collection completed on 8/20/22 indicated that Resident #1 was cognitively impaired with poor decision-making skills, wandered at home or in the previous living settings, and at high risk for wandering. -Record review revealed on 8/20/22 Elopement risk binder was checked to ensure it was up to date. (Picture of Resident #1 was in the binder). -Record review on 8/22/22, facility added pre and posttest for Elopement wandering test to new employee orientation packet and all staff were oriented to the elopement wandering test for employee files. -Record review on 8/24/22 facility started Mock Elopement drill 1-2 a week for 4 weeks and monthly to monitor response time and actions taken by staff. Due to the above failure, the facility Administrator was notified of the past non-compliance IJ on 10/07/22 at 1:00 p.m.