STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455637	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1802 S 31st Temple, TX 76504

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** 47243 Based on interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 10 residents (Resident #1) reviewed for accidents and supervision. The facility failed to prevent Resident #1 from eloping on 09/27/2024. The non-compliance was identified as PNC. The facility had corrected the non-compliance on 9/27/2024 before the investigation/complaint began. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings were: During an interview on 11/20/24 at 12:23 PM with Resident #1, he stated he didn't remember what he was going to HEB for. He stated he was going for a machine for his head. Resident #1 was advised there were no machines for his head there and he stated well he doesn't know what he was there for. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident # 1's face sheet, dated 11/27/2024, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnosis that includes Nontraumatic Intracerebral Hemorrhage In Hemisphere, Subcortical (a bleeding into the brain that can occur in the cerebral cortex or basal ganglia), Essential (Primary) Hypertension (a type of high blood pressure that doesn't have an identifiable cause), Contusion and Laceration of Cerebrum, Unspecified, Without Loss of Consciousness, Sequela (a medical diagnosis indicating a brain injury where there was bruising and tearing of the cerebral tissue, but the person did not lose consciousness), Cerebral Infarction, Unspecified (a medical condition where a blood vessel supplying blood to the brain is blocked, resulting in brain tissue damage), Hyperlipidemia, Unspecified (a common condition where there are too many fats in the blood. It's usually asymptomatic but can lead to serious health problems if left untreated), Other Psychoactive Substance Abuse, Uncomplicated, Dysphasia, Unspecified, Personal History of Other Mental and Behavioral Disorders (Mental and behavioral disorders due to psychoactive substance use. Overview . - Mental and behavioral disorders due to multiple drug use and use of other), Cerebral aneurysm, Nonruptured (a bulge in a brain artery that hasn't burst yet), Hemiplegia and Hemiparesis following other Nontraumatic Intracranial Hemorrhage Affecting Right Dominant Side (a person has experienced weakness or paralysis on the left side of their body due to a brain bleed that occurred on the right side of the brain, specifically in the dominant hemisphere). Record review of Resident's # 1 Admission MDS assessment, dated 10/15/2024 revealed a BIMS score of 05 means sever cognitive impairment. Review of Resident #1's care plan dated 11/21/2024 revealed no evidence of wandering or risk for elopement. Record review of witness statement from LVN A dated 9/27/2024 stated she saw Resident #1 all day and he seemed normal. Around noon she noticed that Resident #1 wasn't in the dining room for lunch like he normally is. LVN A stated she didn't see him in his room or in the back patio, so she let the DON and Administrator know that she did not know where Resident #1 is. LVN B told LVN A that she received a call from her family member that someone got kicked out of the store for trying to shoplift a bunch of steaks. CNA A advised LVN A she heard Resident #1 talking about getting some steak and asking his roommate for directions. LVN A advised the DON and the Administrator about the conversation she had with CNA regarding Resident #1. LVN A stated when Resident #1 returned to the building she completed an assessment on him and provided the report to EMS when they came and picked Resident #1 up around 2 PM. Record review of witness statement from LVN B dated 9/27/2024 stated she saw Resident #1 moving around the building as normal. She stated she did not see him trying to leave the building at all. She stated after they started the code pink to search the building for him, she received a call from her family member around 12:45pm that someone got kicked out of the store for trying to shoplift some steaks and she mentioned it to LVN A and CNA A. That is when CNA A stated she overheard Resident #1 asking his roommate how to get to the local grocery store so he can get some steaks. She notified the DON and the Administrator immediately about the information. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/21/24 at 9:35 am with CNA A stated Resident #1 took a shower, and she heard him say he was going to get him some steaks. She stated Resident #1's roommate can come and go, and she figured the roommate was going to get the steak. She went and got the iron, and she asked him where he was going looking all sharp. And he said he was going to get him some steaks. Once Resident #1 finished dressing for the day, she made his bed, and then she went looking for him to give him his tray. She stated he waited until someone came in and snuck out the front door. Resident #1 went to the local grocery store and stole $230 worth of steaks. She stated that LVN B's family member worked at the local grocery store, and she called her and stated someone was in there trying to steal steaks. When LVN B's family member described him, CNA A realized it was him. CNA A said when he got back, Resident #1 was evaluated, and they sent him to the hospital to make sure he was alright. CNA A stated they were in-serviced on Elopement and what to do in case of an elopement, what code pink means and who to notify as soon as they realize the resident is missing. During an interview on 11/20/24 at 12:15 PM with Reception stated Resident #1 got out in the front while she was helping someone else. She stated she did not realize he slipped out. She stated there was a lot going on that day. Receptionist stated a code pink was called. An unknown staff member brought him back from the local grocery story. After Resident #1 returned, EMS was called to bring him to the hospital to have him checked out. Resident #1 was checked out and he was fine. Receptionist denies he tried to get out since being back. She stated he only goes by the door when he is going to a doctor's appointment. The ADM and DON added him to the elopement binder, they went over the elopement process, and they have been doing training every week. During an interview on 11/20/24 at 2:55 PM with DON stated Resident #1 was sitting in the building and a nurse stated she could not find him. DON stated a code pink was called. DON stated she and the ADM went driving around to find him. DON stated someone called and stated they saw someone that looked like a resident. She stated she and the ADM drove by the local grocery store and picked him up. Resident #1 stated he fell while he was out there. Resident #1 denied wanting to go to the hospital, but he was sent anyway to ensure he was alright. Resident #1 returned to the facility from the emergency room with no injuries noted on the paperwork. The DON was advised Resident #1 walking out the door when hospice walked in. DON stated he knows when people come in and out. He was able to get out with the little crack in the door. DON stated he has not tried to escape since. DON stated his family was called and they came down and had a care plan. During an interview on 11/20/2024 at 2:38pm with ADM stated there were two hospice staff that were waiting at the front door. Resident #1 was able to get out the front door when they were coming in. Resident #1 walked to the local grocery store. Resident #1 said that he went to the store to get some steaks. Staff found Resident #1 about an hour later and returned Resident #1 to the facility. Staff were in-serviced on elopement of residents. Resident #1 has not tried to elope since then. Record review of policy Wandering/ Elopement revised December 2023 revealed: It is policy of the facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. The facility course of action prior to surveyor entrance included: Search of facility and surrounding areas. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Checked and accounted for all residents. Staff in the daytime will make rounds every two hours and at nighttime, the staff will make rounds every four hours to ensure the residents are counted for and safe. Observed all exit doorways and alarms in complete working order. Resident #1 was sent to the hospital for ER for evaluation after being located. Medical records review reveled Resident #1 returned to the facility with no issues or follow up appointments. Resident placed on 1:1 supervision after being located. CNA A was assigned to do 1:1 with Resident #1. The staff was in-serviced on Elopement policies and procedures process; ensure residents sign in/out; how to fill out an elopement assessment; informed elopement binders are located at each nurses station on 9/27/2024. Elopement drill was performed. The faculty and staff performed a drill showing they can perform the elopement protocol. The staff stated when a resident is missing, a code pink is called. Then they will start a search of all rooms and once that room is checked, they will place the garbage can outside the door to confirm that room was already checked. Faculty and staff search inside and outside the facility. The facility contacted the alarm company, which a test operation was perform on the doors, locks, and alarms on 09/27/2024. Observation was done by observing the doors which were pushed and left open for 15 seconds and the alarm sounded. The code for the doors were changed. Pink binders were placed at the nurses stations. Once they cannot find the resident, they will call the police and file a missing report. Doors were checked. The alarm company came. Prior to the survey the facility implemented: 1:1 monitoring of the resident until further assessment (target date 1/13/2025). Assess for fall risk. Provided structured activities walking inside and outside, toileting, reorientation, strategies including signs, pictures, and memory boxes. Psych evaluation. There was another resident listed in the elopement binder, but I did not collect information for that resident. Everything was completed on 09/27/2024. Upon admission Resident #1 was considered a low risk. (4) but after the elopement, his score is now at a high risk (11). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 score is currently an 11. He is in the pink binder along with another resident. The 2 residents are in the pink elopement binder and the care plan for Resident #1 is updated. Interviews were conducted with employees who consisted of LVN's (2), Staffing Coordinator/Med Aide (1), CNAs (9), Receptionist (1), and Resident #1 on 11/20-21/2024 from 10:00 am to 11:30 am and revealed they had received in-services on Elopement Response, all were able to state the key elements of the Emergency response plan and elopement policy which was included.