STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675363	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Post Acute Nursing and Rehabilitation	721 Airport Dr Weslaco, TX 78596

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** 40872 Based on observations, interviews, and record review, the facility failed to ensure each resident recieved adequate supervision for one resident (Resident#44) of 2 residents whose records were reviewed for elopements. Resident #44 eloped from the facility undetected on 05/05/23. Resident #44 was able to remove her wanderguard bracelet and exit the facility on 06/24/23. Resident #44 eloped from the facility undetected after removing wanderguard bracelet for a second time 06/26/23. The non-compliance was identified at PNC (Past non-compliance). The Immediate Jeopardy (IJ) situation began on 06/26/23 and ended 06/27/23 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 #44's admission record dated 03/08/24 documented a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses of Primary Osteoarthritis (common form of arthritis; wear and tear arthritis), other Specified Site, Difficulty in Walking, Not elsewhere Noted, Other Abnormalities of Gait, Unspecified Dementia, unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance (group of serious illnesses that affect the mind), Mood Disturbance, and Anxiety. Record review of Resident #44's MDS annual assessment dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. Record review of the Provider Investigation Report revealed Resident #44 eloped on 05/05/23 at approximately 1:32 pm from the facility. Dietary Aide B witnessed Resident #44 walking on the sidewalk outside the facility and notified LVN G. LVN G redirected resident back to facility and assessed Resident #44. Record Review of Progress Note dated 06/27/23 revealed Resident #44 was discharged home with family. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/07/24 at 11:55 am LVN G said from what she could recall, on the day of[Resident #44's] first elopement, Dietary Aide B notified her that Resident #44 was outside the facility. LVN G said she went outside and found Resident #44 walking in the parking lot. LVN G said R#44 was redirected into the facility with no incident. LVN G said that Resident #44 said that wanted to go outside and walk around. LVN G said Resident #44 was placed on 1:1 for 72 hours after this elopement. LVN G added that Resident #44 also had a wander guard placed on her wrist. LVN G said the wander guard was being checked to make sure it was in place and functioning properly every shift. She said it was documented in PCC daily. LVN G said staff was in-serviced on elopement prevention and what to do in case of an elopement. In an interview on 03/07/24 at 2:00 pm the DON said Resident #44 did not have a history of wandering or elopement prior to the incident on 05/05/23. She said wandering evaluations were done upon admission and quarterly to find out if a resident poses an elopement risk. The DON said Resident #44 had a wandering evaluation done upon admission and was not noted to be a risk. The DON said after the incident, she was reassessed again as an elopement risk, and received doctor's orders to have a wander guard placed on Resident #44. The DON said other interventions were to engage Resident #44 in activities throughout the day as well as having her by the nurse's station for supervision. The DON said an in-service on elopement was conducted with staff after the incident. Record Review of care plan updated on 05/05/23 revealed the following interventions were put in place: -1:1 sitter x 72 hours -Provide structured activities -Offer opportunities for outside recreating in safe areas -Complete wandering evaluation tool -Wander guard in place. Monitoring and checking device per facility policy, staff education regarding elopement policies and interventions Record Review of Resident #44 Skilled Administration Record dated 03/12/24 revealed; Wander guard use, check placement each shift to left wrist was checked off day, evening, and night shifts starting on 05/05/23 to 06/26/23. Record review of the facility Provider Investigation Report revealed on 06/26/23 at approximately 5:45 pm Resident #44 eloped from the facility undetected. Resident #44 was located approximately 0.2 miles away from the facility by a busy intersection by the facility SW . SW notified LVN R who was able to redirect Resident #44 back to the facility. Further record review of Resident #44's Progress notes revealed an entry dated 06/24/23 which indicated Resident #44 was found outside of building in front patio. As per progress note the nurse assessed the resident and noted that the resident was not wearing the wander guard bracelet. As per progress note Resident #44 stated she had removed and placed the wanderguard bracelet in a drawer. A new wander guard was placed on Resident #44's left wrist . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/07/24 at 12:25 pm LVN R said he had not worked at the facility for about 5 or 6 months and did not recall the incident on 06/26/23 with Resident #44 and did not wish to speak to the state surveyor. In an interview on 03/07/24 at 2:10 PM the ADON said Resident #44 had been found by the facility SW walking towards the local store about an 8th of a mile from the facility. She said Resident #44 was brought back by LVN R. The ADON said that the investigation found Resident #44 had removed her wander guard. The staff was unable to determine how she did it. After the incident Resident #44 was placed on 1:1 for 72 hours and staff was in-serviced on elopement and wandering . DON said the facility keeps a binder with the names of the residents that have a high risk for elopement. In an interview on 03/07/24 at 3:31 pm the DON said she asked Resident #44 how she had removed her wander guard bracelet and she said Resident #44 did not tell her how. The DON said Resident #44 showed her where she had placed it in her dresser drawer in her room. The DON said Resident #44 was assessed after the incident and was found to have no injuries, no skin tears. The DON said a care plan was conducted with Resident #44's family and the facility was recommending placement at a facility with a locked unit. The DON said family decided to take Resident #44. Resident #44 was discharged by family on 06/27/23 the day after the incident . In an interview on 03/12/24 at 3:00 pm LVN G said she did not recall the incident that happened on 06/24/23 with Resident #44. LVN G was able to read her progress note documented in PCC and said that the resident was outside sitting in the patio area and LVN G said Resident #44 did not have the wander guard on. She said she believed she asked her where it was or how did she remove it, but Resident #44 did not answer . DON said had in-serviced all the staff on elopement prevention. In an interview on 03/12/24 at 3:58 pm the DON said on 6/24/23 Resident #44 was seen sitting outside the facility in the patio area. She said LVN G assessed her and noted that the wander guard was missing. The DON said she asked Resident #44 how she took it off and the resident did not respond. The DON said another wander guard was placed on Resident #44's wrist and the family was notified as well as the nurse practitioner with no new orders given. The DON said staff continued to monitor Resident #44 and continued with activities for her. Record Review of facility in-services revealed the following In-services conducted with staff after each incident: Topic: 05/05/23 Elopement - Supervise residents at all times, head count of all residents, initiate a code yellow Topic: 06/27/23 Elopement - Staff be vigilant in responding to alarms, supervise residents for accidents/elopement and the use and monitor of wander guards. There were 4 LNVs, one RN, and 5 CNAs on all three shifts interviewed on facility policy and procedure related to identifying and monitoring residents with exit seeking tendencies, redirecting, and ensuring residents at risk remained engaged . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Policy titled Elopements and Wandering Residents dated 11/21/22 states; Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.