STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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** 49415 Based on observation, interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for 1 of 4 residents (Resident #27) reviewed for accidents and supervision. 1) The facility failed to ensure Resident #27 had adequate supervision when he eloped from the facility on 11/12/24 at 4:41 p.m. The resident left the building through a door which did not sound an alarm when he exited. On 11/13/24, the police found Resident #27 when he attempted to enter a school. The police returned Resident #27 to the facility at 8:24 a.m. Resident #27 was gone from the facility over 15 hours and his whereabouts during the time he was missing were unknown. 2) The facility failed to ensure all exit doors were armed to go off with an alarm sound to notify staff the door was opened. The noncompliance was identified as PNC, past non-compliance. The IJ, Immediate Jeopardy, began on 11/12/24 and ended on 11/13/24. The facility had corrected the noncompliance before the survey began. This deficient practice placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . Findings included: Record Review of Resident #27's face sheet revealed he was a [AGE] year-old male, admitted to the facility for respite care on 11/4/24 and was discharged on [DATE]. Resident #27's diagnoses included: Unspecified Dementia (loss of memory, language, problem solving and other thinking abilities that interfere with daily life), Behavioral Disturbance (can include changes in mood, perception, thoughts and behavior), Psychotic Disturbance (a mental illness that causes a person to lose touch with reality), Mood Disturbance (mental health condition affects your emotional state), Anxiety, Type 1 Diabetes Mellitus (condition where the pancreas make little or no insulin, which leads to high blood sugar levels), and Depression. (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 #27's admissions Minimum Data Set/MDS assessment, dated 11/17/24 revealed a BIMS score of 00 which indicated severe cognitive impairment. The MDS showed the resident's wandering impact placed him at a significant risk of getting to a potentially dangerous place. Also, Resident #27 was frequently incontinent of bowel and bladder. Record Review of Resident #27's Care Plan dated 11/4/24, showed resident is an elopement risk . Disoriented to place, Resident wanders aimlessly and has wander guard, designed to support the safety and independence of residents by monitoring their movements and gently preventing them from unintentionally leaving the facility, to left leg. The facility was to intervene with these behaviors by distract resident from wandering by offering pleasant diversions .resident prefers and redirect from doorways and exits. Also, Resident #27 has impaired cognitive function/dementia or impaired thought processes .dementia . Furthermore, the Care Plan showed resident was at risk for falls. Record Review of Assessments revealed Resident #27 had a Wandering Risk Scale completed on 11/7/24 which showed the resident to be High Risk to Wander. Record Review of Progress Notes dated 11/17/24 by RN-E stated, Patient continues to receive one on one care after an elopement . Record Review of Frequent Observation Log every 15 minutes for Resident #27 reflected it started on 11/13/24 at 8:15 a.m. - 11/18/24 at 6 p.m. when resident was discharged . Interview on 12/18/24 at 8:51 a.m. with Administrator/Admin stated Resident #27 came to the facility for 2 or 3 weeks for respite care. He had a Wander guard placed on at admission. This was per family request as Resident #27 had attempted to leave family's home and would get lost. Admin stated resident was exit seeking, but never tried to exit the building. Admin stated on 11/12/24, around 5 p.m., RN-F noticed Resident #27 was not in the dining room for dinner as was his usual. Admin stated staff searched the facility and he had three people drive around to look for Resident #27 outside of the facility. Admin stated he looked at the cameras and saw Resident #27 left the building at 4:41 p.m. through the 200 hall doors where they were doing remodeling. He stated the door was usually alarmed and was on and working when they checked it with the police after Resident #27 eloped on 11/12/24. Admin stated they did not know why the alarm did not go off and they were unable to determine why the alarm did not sound. Admin stated the next morning on 11/13/24 at 8 a.m., the police found Resident #27 as he was trying to enter an elementary school 1.1 miles away from the facility. EMS, Emergency Medical Services, checked out Resident #27 and cleared him. Resident #27 refused to go to the hospital and family was notified. Admin stated Resident #27 did not have his Wander guard on when he returned to the facility. Admin stated the facility did one on one checks every 15-minutes on Resident #27 until he was discharged from the facility. Also, Admin stated they had staff do 15-minute door checks on the door Resident #27 went out of until a contractor came out the next day, on 11/13/24, to ensure the door was functioning correctly. Furthermore, Admin stated they in-serviced all staff on elopement procedures and had nurses check all doors for an alarm at the beginning of every shift. On 12/18/24 at 10:21 a.m. interview with CNA-A stated she was not working when Resident #27 eloped. CNA-A stated if she had a resident who was an elopement risk, she would sit with them, walk around with them, or redirect them with an activity. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/18/24 at 10:38 a.m. interview with LVN-B stated if she had a resident who was an elopement risk, she would do frequent checks on them and she would check the doors to see if the alarm was on. LVN-B stated she was not at work the day Resident #27 eloped. LVN-B stated Resident #27 would walk continuously throughout the building. She stated she always checked the doors at the beginning of every shift to ensure they were working. LVN-B stated she did complete elopement training after Resident #27 eloped. On 12/18/24 at 1:43 p.m. interview with Resident #27's family member was attempted. A voice mail was left but no response was received. Observation on 12/18/24 at 1:46 p.m. with Admin revealed that all the doors in the facility were armed, and alarms went off each time the doors were opened. Record Review of Work Acknowledgement with Contractor-C on 11/13/24 to test if door alarms were working with Contractor-D. Record Review of Frequent Observation Log for door checks on 200 halls reflected observation was conducted every 15 minutes from 11/12/24 at 6:30 p.m. through 11/13/24 at 12 a.m. Record Review of the facility's provider initial report, PIR, revealed the Admin interviewed LVN-B who worked 11/12/24, 6 a.m. - 6 p.m. and stated resident was up and walking all over the facility as usual. He is easy to be redirected to his room or dining room or the activity area. Also, the Admin interviewed RN-F who stated, I observed .all over the facility .I noticed that he was not in the dining room nor in the room and notified all staff of code pink (missing resident) and we initiated the search for the missing resident. Record Review of the facility's In Service Training Attendance Roster, dated 11/11/24 showed staff, including CNA-A, LVN-B and RN-A were trained on Missing Resident Policy, Code Pink. Record Review of the facility's Wandering and Elopements, undated, reflected under Policy Statement - The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Record Review of facility's Emergency Procedure - Missing Resident policy, undated, revealed under Policy Interpretation and Implementation. 1. Residents at risk for wandering and/or elopement will be monitored, and staff will take necessary precautions to ensure their safety.