STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage at Turner Park Health & Rehab	820 Small St Grand Prairie, TX 75050

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 - Actual harm

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 46403

Based on observation and interview, and record review, the facility failed to provide adequate supervision and ensure the resident environment remains free of accident hazards as is possible for 2 of 2 (male unit and female unit) secure units reviewed for accidents and hazards.

1. The facility failed to ensure the emergency exit door was locked. Resident #1 was able to exit from the back door and then fell outside while she ran from staff from the secure unit. Resident #1 subsequently had a serious injury to the forehead which resulted in her having three stitches.

2. The facility failed to have a monitoring system for residents who wanted to go outside in the courtyard from the dining room exit door to the outside smoke area in the secured unit.

These failures could place residents at risk of accidents, injury, or being left outside exposed to physical environment elements.

Findings included:

1. Record Review of face sheet dated 01/12/2024 revealed Resident #1 was an [AGE] year-old female admitted on [DATE]. Her diagnoses included: dementia (impaired ability to remember, think, or make decisions that interferes with doing every day activities), agitation, anxiety disorder (persistent and excessive worry that interferes with daily activities), hypertension (high blood pressure is when the pressure in your blood vessels is too high 140/90 mmHG or higher) chronic pain(long standing pain that persists beyond the usual recovery period), and epilepsy (a brain condition that causes recurring seizures).

Record review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 had no BIMS score noted which indicated severe cognitive impairment. Record review of behavior section of the MDS assessment revealed a score of 1 for physical behavioral symptoms directed toward others (hitting, kicking, etc.) and verbal behavioral symptoms directed toward others (screaming, etc.) which indicted this behavior occurred 1 to 3 days. Record review of wandering section of the MDS assessment revealed a score of 0 which meant no behavior exhibited. Record review of health condition section of MDS assessment revealed no falls noted.

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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 - Actual harm Residents Affected - Few	Record review of Resident's #1's care plan dated 01/12/24 reflected: Resident resides in the Secure Care Unit, related to diagnosis of dementia (or related diagnosis) and risk for elopement. Disoriented to place Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the Secure Care Unit. Interventions: Admit to Secure Care unit per MD orders. Record review of Resident#1's incident report dated 01/16/24 at 10:45 AM was completed by LVN T revealed: The resident was walking in the hallway and went out the back emergency door and fell . The resident is confused and could not answer. She only said, 'you got me.' The incident report reflected a head to toe assessment was performed, and the resident was noted to have a laceration that required first aide. The resident was not taken to the hospital. The incident report reflected LVN A and CNA J were witnesses. The incident report's post incident section reflected: no injuries observed post incident. It also reflected the physician and responsible party were notified. Record review of the fall assessment sheet dated 01/16/24 at 11:00 AM, completed by LVN T, revealed Resident #1's blood pressure was 132/74 and pulse was 80. Record review of fall assessment sheet revealed no injuries. Record review of Resident #1's progress notes was completed by ADON M, dated 01/16/24 reflected, Resident #1 was transferred to a hospital on 01/16/2024 at 11:00 AM related to fall with laceration to forehead. Interview on 04/10/24 at 8:27 AM with Resident #1s family member (Family Member #1) revealed staff (unknown) reported to her that Resident #1 was running away from staff and trying to go out the back door. Family Member #1 revealed staff reported she fell and hit her head and was bleeding. Family Member #1 revealed Resident #1 had to get three stitches. Family Member #1 revealed Resident #1 did not return to the facility. Interview on 04/10/24 at 10:15 AM with Maintenance revealed Resident #1 went out the back emergency door. He stated the alarm sounded when the door was opened. Interview on 04/10/24 at 10:45 AM with Resident #1's family member (Family Member #2) revealed staff (unknown) reported to her that Resident #1 was running from staff and tripped going out the back door and had a cut to her forehead. Family Member #2 revealed Resident #1 cannot run at all and used a walker. Family Member #2 revealed Resident #1 had to get three stitches to the forehead. Interview on 04/10/24 at 1:30 PM with CNA J revealed she did not recall Resident#1. Interview on 04/10/24 at 1:55 PM with LVN A revealed Resident #1 had fallen on the concrete outside, and she was bleeding. LVN A revealed the paramedics picked her up. Interview on 04/10/24 at 2:20 PM with LVN L revealed she saw Resident #1 outside on the ground from another resident's room. LVN L revealed the paramedics came and took her to the hospital. LVN L revealed she did not recall anything else from that incident. Interview on 04/10/24 at 2:58 PM with ADON A revealed she was not the ADON on duty at the time of incident. ADON A revealed Resident #1 tried to get out of the secure unit back door. ADON A revealed Resident #1 fell and had a laceration to her forehead and was transferred to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 04/10/24 at 3:12 PM with the DON revealed Resident #1 tried to get out the backdoor and ran away from staff. Resident#1 fell , and the paramedics were called. The DON revealed the family took Resident#1 out of the facility. The DON revealed she called the hospital to check on patient and no information was given. Interview and record review at 04/10/24 at 3:55 PM with the Administrator revealed she did not report Resident #1's incident because it was a witnessed fall. The Administrator revealed the facility was not aware Resident #1 had to get stitches. 2. Observation on 04/10/24 at 8:47 AM of the male secure unit revealed no visible staff when entering the secure unit and dining room area. Observation on 04/10/24 at 9:00 AM revealed the dining room door going to the courtyard was unlocked and opened with no alarm sound. Observation of the courtyard revealed it is fenced in. Observation of the dining room door to enter back into the facility did not alarm or lock. Interview on 04/10/24 at 9:16 AM with LVN J revealed residents went in and out the door to smoke. LVN J revealed resident were supervised during smoke breaks always. Interview on 04/10/24 at 10:15 AM with Maintenance revealed the male secure unit dining room door had never had an alarm or locking mechanism since he had been at the facility the last 2 years. Interview on 04/10/24 at 2:10 PM with CNA R revealed residents went in and out the door to smoke. CNA R revealed residents could go outside when the weather was bad, like when it was raining or when it was too hot, and could get hurt. Interview on 04/10/24 at 2:20 PM with LVN L revealed residents in the male secure unit went in and out the door. LVN L revealed this could be a security issue, and it was possible for someone to jump the fence and come into the facility. LVN L revealed a resident could be left outside. Interview on 04/10/24 at 3:12 PM with the DON revealed the dining room door that led to the courtyard/smoke area had always been unlocked and unalarmed. The DON revealed the door has always been this way. The DON revealed residents could get outside and be exposed to the elements. Interview on 04/10/24 at 3:55 PM with the Administrator revealed the dining room door that led to the courtyard/smoke area had always been unlocked. The Administrator revealed corporate was contacted about the door not having a locking mechanism or alarm system. The Administrator revealed the facility's corporate reported the secure fence made the unit secured. The Administrator revealed residents could be unattended and exposed to inclement weather. Record review of facility's current, undated Secure Care Program Admission Criteria and Process policy reflected the following: The goal of the Secure Care Program is to meet the individual needs of residents living with Dementia. The Secure Care Program will provide a safe environment .The resident must score 10 or greater on the elopement risk assessment. An attempt was made to contact LVN T via telephone, but the attempt was unsuccessful. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Administrator and DON were asked to provide the contact information for ADON M, but the contact information was not provided prior to exit.