STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on observation, interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment, which included but not limited to receiving treatment and supports for daily living safely for one (Resident #1) of four residents reviewed for environment. The facility failed to ensure Resident #1's walls in his room were in good repair. The facility also failed to ensure Resident #1's air conditioning unit was properly installed in his room. The failures could place residents at risk for a diminished quality of life due to the lack of a homelike environment. Findings included: Record review of Resident #1's Quarterly MDS assessment, dated 08/24/24 revealed he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included hypertension, hip fracture, aphasia (a disorder that affects how you communicate), cerebrovascular accident (an interruption in the flow of blood to cells in the brain), Non-Alzheimer's Dementia, traumatic brain injury, malnutrition, and psychotic disorder. His BIMS score was 0 out of 15, which revealed he was severely cognitively impaired. Observation on 09/03/24 at 11:50 AM of Resident #1's room revealed there was a hole in the corner of the wall above the base baseboard located near the right side of the room. There was a gap above the upper right side of the air conditioner. The outside of the facility was visible from the gap. Resident #1 appeared to be confused and did not answer the surveyor's questions. Review of the maintenance log titled, Task Export Report, undated, revealed there were no repairs made to the gap above the air conditioner or the hole in the corner of the wall above the baseboard. Interview with CNA F on 09/03/24 at 11:59 am revealed he did not know there was a gap above the air conditioner and a hole in the wall above the base boards on the right side of the room. He stated he would inform the nurse and Maintenance Supervisor if repairs were needed in a resident's room. He stated the Maintenance Supervisor was responsible for making repairs at the facility. He stated the gap above the air conditioner and the hole in the wall did not create a home like environment for the resident. (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
	455733	A. Building B. Wing	09/06/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Maintenance Supervisor on 09/04/24 at 10:30 AM revealed he was responsible for facility repairs. He stated he made rounds throughout the facility at least four times a day. He stated the facility had a program called Champion Rounds (staff are assigned rooms at the facility to check on resident concerns). He stated staff would complete a form regarding any maintenance concerns. He stated his primary focus during rounding at the facility was the exterior. He stated he did not know there was a gap above the air conditioner and a hole in the corner of the wall in Resident #1's room. He stated the gap above the air conditioner needed to be sealed. He stated sheet rock and spackle was needed to repair the hole in the corner of the wall. He stated there were no risk to Resident #1. He stated the gap above the air conditioner and the hole in the corner of the wall did not affect Resident #1's home like environment. Interview with the Administrator on 09/06/24 at 5:18 PM revealed she was not aware there was a gap above the air conditioner and hole in the corner the wall in Resident #1's room. She stated the Maintenance Supervisor made daily rounds at the facility. She stated the Maintenance Supervisor was actively making repairs throughout the facility. Record review of the facility policy titled Preventative Maintenance/Work-Order Request, dated 2003, revealed The facility will repair or replace damaged/broken equipment or building amenities as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 - 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** 42283 Based on observations, interviews, and record reviews, the facility failed to ensure residents received adequate supervision and the environment was free from accident hazards for one (Resident #2) of four residents reviewed for supervision. Inside the facility the courtyard could not be viewed due to the blinds being closed and there was no camera monitoring of the courtyard. The facility failed to adequately supervise Resident #2. On 08/17/24 RN B was making rounds around 6:40 AM and Resident #2's roommate reported her missing. RN B stated he and staff searched the facility for Resident #2. He stated the Administrator, police, and ADON were notified. Resident #2 was able to exit the dining room and enter the courtyard. The alarms to the doors had been removed (08/09/24 by the Maintenance Supervisor) prior to the incident. Once Resident #2 was in the courtyard, the resident was locked into the courtyard as demonstrated by the surveyor observation. This courtyard and the locking of the doors can be considered an environmental hazard as Resident #2 was trapped. Resident #2 was found by staff around 8:50 AM on the ground by her wheelchair in the courtyard by the dining room and male secure unit; and she complained of pain to both knees. An Immediate Jeopardy (IJ) was identified on 09/04/24 at 5:30PM. The IJ template was provided to the facility on [DATE] at 5:52PM and signed by the Administrator. While the IJ was removed on 09/05/24 the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. This failure placed residents at risk for not being adequately supervised and the potential for serious injury and/or death. Findings included: Record review of Resident #2's Quarterly MDS assessment, dated 08/21/24 revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included hypertension, renal insufficiency (poor function of the kidneys that may be due to a reduction in blood-flow to the kidneys caused by renal artery disease), urinary tract infection, hyperlipemia (too many lipids (fats) in her blood), Non-Alzheimer's Dementia, anxiety disorder, depression, and schizophrenia. Her BIMS score was 8 out of 15, which revealed she was moderately cognitively impaired. Her behavior section revealed wandering presence and frequency occurred one to three days. Her functional status revealed she used a walker and wheelchair. She required setup or clean-up assistance with eating, sit to stand, transferring, walk 10 feet, walk 50 feet with two turns, and walk 150 feet. She required supervision or touching assistance with bathing, dressing, and personal hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's Care Plan, dated 08/12/24 and revised 08/17/24, reflected Resident #2 was at-risk for elopement as evidenced by cognitive impairment. Her goal was to remain safe within the facility unless accompanied by staff or other authorized person. Her interventions were assess/record/report to MD risk factors for potential elopement such as wandering, repeated requests to leave facility, statements such as I'm leaving and I'm going home. Attempts to leave the facility, elopement attempts from previous facility, home, or hospital. Supervise closely and make regular compliance rounds whenever resident was in room. Determine the reason the resident was attempting to elope. If resident was exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, and etc. Review of Resident #2's Elopement Risk, dated 08/17/24, reflected she was a high risk of elopement. Review of the facility's Provider Investigation Report, dated 08/22/24, reflected on 08/17/24 at 6:50 AM, the facility conducted a search throughout the facility, called 911, and continued searching for Resident #2. Resident #2 was found on the ground by her wheelchair in the courtyard by the dining room and men's secure unit. EMS was on-site, Resident #2 was at baseline and refused to be sent to the hospital for further evaluation. A head-to-toe evaluation was completed and no injury was noted at the time of the assessment. Resident #2 complained of pain to both knees and the physician was notified. Neuro assessment and skin assessments were completed. The Administrator followed up with Resident #2 to ensure her safety and well-being in the facility and spoke with the RP. Resident #2 initially refused to go to the hospital but was sent to the ER per family request. Lab results from the hospital revealed she had a UTI. The facility conducted an elopement drill and would complete three elopement drills per week for the next four weeks. The facility staff were educated on elopement prevention and response policy and emphasized on checking courtyards during searches. Staff were educated on the importance rounding during shift change and two hour rounding. An abuse and neglect in-service was completed. Elopement risk assessments were completed. Resident #2's care plan was updated. Elopement assessments were completed with doctor's orders. Resident #2 was placed in the female secure unit. Resident will be assessed for elopement risk after completion of UTI medication. Observation on 09/03/24 at 1:05 PM revealed the Administrator and Surveyor exited one of the doors in the dining room to enter the male secure unit courtyard. Once the door was opened the alarm sounded. When the door closed the alarm shut off. There were windows with closed blinds facing the courtyard. The layout of the courtyard was in between the male secure unit and the main dining room. There was a sidewalk in the middle of the courtyard. There were air conditioning units on both sides of the courtyard. Once in the courtyard the Surveyor and Administrator were unable to re-enter the facility. The Administrator and Surveyor were not visible from inside the facility once outside in the courtyard. There were no cameras in the courtyard. Not having cameras in the courtyard also contributed to the area being a hazard. The Administrator had to use her phone to call staff to open the door from inside the facility. Any staff or resident using the main dining room could enter the courtyard. There were no residents by the doors. However, there were vending machines next to the doors that residents access throughout the day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Administrator on 09/03/24 at 1:09 PM revealed Resident #2 had moments of confusion. She stated Resident #2 was a new admission and had not had any previous elopements while at the facility. Resident #2 went missing around 6:47 am on 08/17/24. She stated Resident #2 got turned around and exited the door in the dining room near the vending machine. She stated the door did not have an alarm and was unlocked. She stated the door could be pushed open into the male secure unit courtyard and once outside the dining room door locked when closed. She stated Resident #2 fell out of her wheelchair (unknown how she fell out of her wheelchair) and was found around 8:50 AM in between two air conditioning units. She stated the temperature outside was in the 80s (Fahrenheit). She stated Resident #2 was assessed by the nurse and did not sustain any injuries. She stated Resident #2 complained of pain to her knees. She stated the physician was notified. The Administrator stated Resident #2 refused to go the hospital but the RP agreed to have her sent to the hospital. The Administrator stated Resident #2 received an X-ray at the hospital and no fractures were noted. She stated Resident #2 was not previously on the female secure unit but was moved to the female secure unit after the elopment She stated an alarm was placed on the doors after the incident happened. She stated staff were in-serviced regarding elopement. She stated Resident #2 was moved to the female secure unit at the facility. She stated staff completed elopement drills. Interview with the Maintenance Supervisor on 09/04/24 at 10:30 AM revealed there was not an alarm on both doors in the dining room near the male secure unit courtyard. He state the alarms on the dining room doors facing the male secure unit courtyard were removed on 08/09/24 and replaced on 08/26/24. He stated the alarms on the door were removed because HHSC Life Safety informed the facility the wrong alarms were on the doors. He stated there was no alarm on the doors when Resident #2 was missing. Observation of Resident #2 on 09/04/24 at 1:20 PM revealed she was sitting in her wheelchair in the female secure unit. She was clean, well-groomed, and appropriately dressed. She was free from any odors. She displayed no obvious signs or symptoms of distress. There were no concerning marks or bruises noted on her person. There were no noted concerns regarding her appearance. During an attempted interview with Resident #2 on 09/04 at 1:20 PM, it was noted that Resident #2 was pleasantly confused and was unable to participate in a reliable interview due to cognitive impairment. However, she reported that she had bruising and was in pain after the incident. Review of the facility's policy title, Elopement Prevention, dated January 2023, reflected, every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. An Immediate Jeopardy (IJ) was identified on 09/04/24 at 5:30PM. The IJ template was provided to the facility on [DATE] at 5:52PM and signed by Administrator. A Plan of Removal was requested at that time. The facility's Plan of Removal was accepted on 09/05/24 at 2:09 PM and reflected the following: The facility failed to ensure Resident #2 was free from accident hazards. The facility failed to ensure Resident #2 could enter and exit the facility from the male secure unit courtyard. All residents in the main building have the potential to be affected by this alleged deficient practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: As of 9/4/2024 Resident #2 resided on the facility's female secured unit. As of 9/5/2024 Door #1 (located near the courtyard gate) has been locked by maintenance and will remain locked at all times since it is not an exit door or door of egress. Door #2 in the dining room (designated as the 2nd exit door for the courtyard) has had mag locks installed by our fire safety contractor and will remain locked at all times but will disengage when the fire alarm system is activated. The Medical Director was notified by the Administrator of this plan on 9/4/2024. An Ad Hoc QAPI meeting was held on 9/4/2024. In-services: All staff will be in-serviced by 9/5/2024 by the Admin/designee regarding the following and all staff not in-serviced by 9/5/2024 will not be allowed to work their assigned position until completion of these in-services. All new hires, PRN, and agency staff will be in-services prior to the start of their assignment: This will be ongoing. Admin and ADON were in-serviced by Compliance Nurse. Abuse and Neglect All staff must respond immediately when the door alarms are triggered and intervene as appropriate. Elopement Prevention and Response Monitoring: The Admin/Maintenance and/or designee will monitor all doors functioning, including the dining room door and alarms 5 times per week. Monitoring began 9/4/2024 and will continue x 4 weeks. Any issues identified will be addressed immediately. Monitoring: Record review of facility in-service training reports dated 09/04/24 revealed facility staff from the 6:00 AM - 2:00 PM, 2:00 PM - 10:00 PM, and 10:00 PM -6:00 AM weekday and weekend shifts and management were in-serviced regarding elopement prevention and response, elopement Risk and protection, elopement risk and prevention, if a door alarm was triggered, staff must respond immediately to assess the situation, intervene and redirect residents as appropriate, door alarm response, and abuse/neglect policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455733	A. Building B. Wing	09/06/2024

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews with the Administrator, ADON, Staffing Coordinator, LVN A, RN B, LVN C, CNA D, and CNA E on 09/06/24 were between 12:00 PM and 5:18 PM revealed staff from all shifts and various disciplines were in-serviced regarding elopement prevention and response, elopement Risk and protection, elopement risk and prevention, if a door alarm was triggered, staff must respond immediately to assess the situation, intervene and redirect residents as appropriate, door alarm response, and abuse/neglect policy. Staff stated they were aware there was a keypad placed on one of the doors in the dining room facing the male secure unit courtyard. Staff stated they were aware the courtyard was for the residents located on the male secure unit with supervision. They stated they understood what to do and where able to demonstrate competency by responding to drills. Observation on 09/05/24 at 4:15 pm of both doors in the dining room near the male secure unit courtyard revealed one door was permanently sealed and the other door had a keypad installed. The keypad was for staff to access the male secure unit courtyard. The courtyard could not be accessed without a key code, and once outside in the courtyard the staff could use a key code to re-enter the facility through the male secure unit. The alarm was triggered and staff from various disciplines ran to the dining room to respond to the door alarm. A code could be used to stop the alarm. Interview with RN A on 09/06/24 at 4:32 PM revealed he was informed by Resident #2's roommate that she was not in her room. He stated Resident #2 went missing around 6:40 AM and was found around 8:50 AM. He stated Resident #2 was found on the ground in the male secure unit courtyard in between two air conditioning units. He stated there were no alarms on the doors in the dining room facing the male secure unit courtyard. He stated Resident #2's wheelchair was next to her. He stated Resident #2 appeared to be confused. He stated he assessed Resident #2 and she did not sustain any injuries. He stated Resident #2 complained of pain to both of her knees. He stated she had a history of knee pain. He stated Resident #2 was placed on the female secure unit due to her elopement. He stated Resident #2 refused to go to the hospital. He stated RP requested Resident #2 be sent to the hospital. Interview with the Administrator on 09/06/24 at 5:18 pm revealed she supervised her staff to ensure policies/procedures were being followed by monitoring, re-educating staff, rounding, and spot checking. She stated she checked the staff's work and followed up with them. She stated during morning meetings, stand down meetings, and other meetings throughout the day accomplishments were discussed. She stated the IJ occurred because Resident #2 exited out of the door to the male secure unit courtyard and was not able to re-enter through the door. She stated the IJ would have been prevented had the door alarms not been removed. She stated the lock with a keypad on one door and permanently locking the other door would prevent the incident from reoccurring. She stated staff were in-serviced regarding frequently monitoring the doors to see if the alarms went off, seeing if staff responded to alarms, elopement, abuse, and neglect. The Administrator was notified the IJ was removed on 09/05/24, however the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal.