STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455819	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Heights Health and Rehabilitation Center	4825 Wellesley St Fort Worth, TX 76107

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** 35152 Based on observations, interviews, and record review, the facility failed to ensure an environment that was free of accident hazards and that each resident received adequate supervision to prevent elopement for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to ensure Resident #1 was provided with adequate supervision and free of potential harm when he eloped from the facility on 07/30/2024 without staff knowledge. The facility was informed of the elopement by a family member who reported the resident was found 8 miles from the facility. The facility failed to ensure staff rounded often to ensure all Resident #1 was in the facility prior to leaving at the end of their shift or upon starting their shift on 07/30/2024. A past non-compliance Immediate Jeopardy (IJ) situation was identified on 08/02/2024 at 1:40 PM. The Immediate Jeopardy began on 07/30/2024 and ended on 07/31/2024. The facility had corrected the non-compliance before the surveyor began. These failures placed residents at risk of harm and, serious injury, or death. Findings included: Record review of Resident #1's Face Sheet dated 08/02/2024 reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had diagnoses which included alcohol abuse with alcohol-induced psychotic disorder (psychosis after the intake of alcohol), cognitive communication deficit (trouble reasoning and making decisions), cerebral infarction (disrupted blood flow to the brain), dysphasia (the ability to produce and understand language), vascular dementia, moderate (fourth stage of dementia - symptoms are more prominent), anxiety disorder (sudden feelings of anxiety or panic), major depressive disorder (persistent feelings of sadness and lack of interest), and gastrostomy status (surgical opening in the stomach for nutritional support). Record review of Resident #1's MDS assessment dated [DATE] reflected he had no BIMS score, which indicated severe cognitive delay. Staff assessment for mental status indicated short-term memory problems and difficulty in new situations for daily decision-making skills. Resident #1 had a feeding tube and was totally dependent for feeding. He was independent for transfers, walking, and dressing. Wandering behaviors were not exhibited. (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
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(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	Record review of Resident #1's Care Plan dated 04/30/2023 and updated 07/30/2024, reflected, Focus: [Resident #1] has impaired cognitive function/dementia or impaired thought processes r/t cognitive deficit, cluster of septic arterial embolisms, substance abuse. [resident #1] does not typically verbally respond to BIMS and PHQ-9 questions. [Resident #1] has a communication problem r/t cognitive deficit, cluster of septic arterial embolisms, substance abuse. [Resident #1] speaks minimally and only to certain individuals. Interventions: Alternative interventions: promote use of non-verbal communication, ask yes or no questions when inquiring about wants/needs, provide sense of security, reduction of noise, approach with calming voice, validate non-verbal expressions of emotion, provide sensitivity to personal space. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. [Resident #1] needs assistance with all decision making. Refuses to use communication board. Focus: At risk for elopement as evidenced by: History of attempts to leave facility unattended, 4/30/24-went outside through front door, 7/30/24-went out through his window. Interventions: 15-minute checks. May need to go to a private room on secured unit temporarily until family is able to visit and calm [Resident #1's] frustration. Moved to secured unit. SW to try to move resident to another facility that has secured doors. UA collected, Assess/record/report to MD risk factors for potential elopement such as: Wandering, Repeated requests to leave facility, statements such as I'm leaving I'm going home, attempts to leave facility, elopement attempts from previous facility, home, or hospital. Supervise closely and make regular compliance rounds whenever resident is in room. Determine the reason the resident is attempting to elope. Is the resident looking for something or someone? Does it indicate the need for more exercise? Intervene as appropriate. Distract resident from elopement attempts by offering pleasant diversions, structured activities, food, conversation, television, books. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. Record review of the Elopement Risk assessment dated [DATE] and signed by LVN H, reflected, a score of 18, Elopement risk. Record review of the facility's incident report, dated 07/30/2024 at 7:15 AM and signed by the DON, reflected, The Director of Nurses received a call from resident's [family member] at 7:15am, [family member] stated that an employee at [a restaurant 8 miles away] had called her and told her [Resident #1] was there. DON immediately got van driver to go to [restaurant] to pick up resident When DON went to resident's room to talk with roommate, DON found [Resident #1's] window open and screen not in place. It appears resident went out his window. [Resident #1's] roommate stated [Resident #1] was in the room when he went to sleep, and he just found out resident was gone. Charge nurse stated the last time he seen [Resident #1] was between 4 and 4:30am. Van driver and [Resident #1] returned to the facility at approximately 8:15am. [Resident #1] returned Resident was immediately taken to the secured unit. [Resident #1] was able to ambulate into the facility into his new room. [Resident #1] appeared tired but otherwise appeared to be in good health. Intervention: Resident moved to secured unit into a room where the window opens up into a secured patio. (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 08/02/2024 at 8:55 AM with the Administrator and DON, the DON stated Resident #1 eloped from the facility on 07/30/2024. She stated Resident #1 did not speak and did not have a BIMS because of his limited ability to communicate. She said and was discovered at a restaurant 8 miles from the facility by a worker who called Resident's family. She said Resident #1 carried a paper with family phone numbers on it. The DON said she received a call from Resident #1's family member at about 7:15 AM and immediately sent the van driver to pick up Resident #1. She stated RN E did not check on Resident #1 after an ordered treatment was provided at 4:15 AM. CNA C did not do walking rounds to check on residents at the end of his shift at 6:00 AM. She said LVN G and CNA A and CNA B came on shift at 6:00 AM and did not check on Resident #1 either. She stated she notified the MD who wanted a follow up when Resident #1 returned. She stated Resident #1 did have a decrease in Depakote recently due to recent labs that reflected abnormal liver function. She said that may have cause a change in Resident #1's behavior. She said Resident #1 had a follow up appointment with Psychiatry to reevaluate medications on 08/05/2024. The DON said staff were not aware Resident #1 was gone from the facility until she informed them after 7:15 AM. She said when she went into Resident #1's room, the curtains were in front of the window, but the window was open, and the screen pulled back. She said Resident #1's roommate said he did not hear anything as he was sleeping. The DON said Resident #1 first came to the facility in 2020 and was in the secured unit. She said during Covid-19, he was placed off the unit in a Hot Zone, for isolation. She said Resident #1 eloped through a window at that time as well. She said Resident #1 went to another facility then a group home, but the family wanted him to return to the facility outside the secured unit. The DON said when Resident #1 returned to the facility he was an elopement risk but did not show any elopement behaviors. She said the elopement assessment completed on 07/30/2024 was 20 which indicated elopement risk. She said the family has agreed to leave Resident #1 in the secured unit while they secure alternate placement and arrangements for him. The Administrator said staff did not complete rounds to ensure residents were in the facility and did not know Resident #1 had eloped. The DON stated RN E administered a water bolus at 4:00 AM on 07/30/2024 and did not see the resident after that. She said when she found out of the elopement at 7:15 AM, she called a Code Orange which meant elopement. The Administrator said he was informed at about 7:15 AM and directed a discussion with family to have Resident #1 placed in the secured unit, start in-services on walking rounds, abuse and neglect, and elopement procedures, and completed elopement assessments on all residents. An observation and interview on 08/02/2024 at 10:25 AM reveled Resident #1 in his room, in the secured unit, sat on his bed. Resident #1 only responded by nods to yes/no questions. There was a communication board in the corner of the room, Resident #1 nodded no when asked if he used it. The window in the room was open and screen was bent back on the left corner. Resident #1 laughed and nodded yes when asked if he did that. He nodded yes when asked if he opened the window and screen in his last room when he eloped. He nodded yes when asked if he walked 8 miles and a restaurant worker called his [family member]. He nodded yes when asked if he was tired, if it was dark, if he had shoes on. He nodded yes when asked if he liked the facility and no when asked if he wanted to leave again. He did not answer when asked if he knew where he was going or why he eloped. In an interview on 08/02/2024 at 10:37 AM, the Corporate Compliance Nurse stated the facility did fail to ensure Resident #1 was safe from the hazards of elopement, but the Administrator and DON have implemented all actions needed to correct the failure on 07/30/2024 and 07/31/2024. (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 08/02/2024 at 10:55 AM, the SW stated she was unable to get a BIMS for Resident #1. She said she used pictures but his limited ability to communicate contributes to his sever cognitive ability. She said she was looking for a group home that met Resident #1's tube-feed needs. She said the DON already implemented in-services for all staff to address elopement and abuse and neglect on 07/30/2024. She said there was an elopement drill and all residents' elopement assessments were updated also on 07/30/2024. In an interview on 08/02/2024 at 11:03 AM, CNA A stated she came on shift on 07/30/2024 at 6:00 AM and did not do rounds to check on residents. She said she should have because she would have seen that Resident #1 was gone. She said she did not know Resident #1 was gone until the DON called an elopement drill. She stated she received in-servicing on elopement protocol and walking rounds throughout the shift and at the end of shifts to ensure all residents were okay. In an interview on 08/02/2024 at 11:10 AM, CNA B said she came on shift at 6:45 AM on 07/30/2024. She said she was called in to cover so she had been a little late. She said she did not check on the residents when she arrived and then the DON called an elopement drill. She said we all started checking rooms and were told that Resident #1 had eloped. She said Resident #1 would get frustrated and want to leave the facility sometimes. She said that would occur when people did not understand him. She said he had a communication board and computer but rarely used them for communication. She said she should check on residents regularly and when she came on shift to ensure residents were safe. She said she was in-serviced on doing rounds and elopement procedures. She said the DON completed the in-services on 07/30/2024. A telephone interview on 08/02/2024 at 11:33 AM with Resident #1's family member revealed a community member called her to say Resident #1 was in a restaurant near the city center. She said called the facility and informed the DON the Resident #1 was 8 miles from the facility at a restaurant. She said the DON sent staff to get Resident #1. The family member said Resident #1 returned to the facility outside the secured unit at her request. She said she wanted him to have the best quality of life possible. She said she knew he could get frustrated and want to leave the facility at times, but the staff were good at redirecting him. She said she did not know where else Resident #1 could live but did agree to place him in the facility's secured unit while the facility worked with her to find an alternate placement. She said the DON told her that staff had not checked Resident #1's room after about 4:00 AM and then they found the window open, and screen pulled back. In an interview on 08/02/2024 at 1:21 PM, the Maintenance Director stated he checked the door alarms weekly and checked them again on 07/30/2024. He said he repaired the screen in the room where Resident #1 eloped on 07/31/2024. He said the DON in-serviced all the staff on elopement procedures and checking on residents regularly. He said Resident #1 could have been hurt when he eloped and walked 8 miles before being found. He said all staff were responsible to ensure residents were safe. In an interview on 08/02/2024 at 2:45 PM, LVN I stated she worked on the secured unit. She said Resident #1 was on 15-minute checks until further notice from the DON. She stated the DON in-serviced all the staff on elopement protocol, walking rounds, and abuse and neglect. She said Resident #1's care plan had been updated on 07/30/2024 and all residents had an updated elopement risk assessment completed. She said she expected CNAs to tell her where they are at all times and ensure residents were supervised. She said it was all staff's responsibility to ensure residents were safe from accidents or hazards. (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 08/02/2024 at 3:05 PM, Resident #1's roommate stated he had been sleeping when Resident #1 eloped. He stated he did not hear or see anything until the morning when the DON came to ask him about it. In an interview on 08/022024 at 3:10 PM, LVN G said she came on shift on 07/30/2024 at 6:00 AM. She said she had not rounded and did not check on all her residents that morning. She said she did not know Resident #1 was missing when she came to work but would have noticed had she checked on her residents that morning. She said the DON called an elopement drill at about 7:30 AM and that was when she found out Resident #1 had eloped. She said she expected the CNAs to check on residents too, but it was all staff's responsibility to ensure residents were safe and accounted for when they come on shift. She said the DON provided in-services to all staff on elopement procedures, abuse, and neglect, and rounding frequently. A telephone call on 08/02/2024 at 3:18 PM to LVN L revealed no response. In an interview on 08/02/2024 at 3:24 PM, the DON stated she did not give LVN G or RN I counseling because rounding had not been an issue in the past. She stated she planned on monitoring by taking turns with the ADONs and unit managers to do walking rounds. She said she will continue this until rounding becomes a habit for all staff. In an interview on 08/02/2024 at 3:45 PM, the Corporate Nursing Consultant stated she will conduct random checks in the halls and by reviewing documentation to ensure staff are following the facility's rounding expectations. She stated she will monitor resident's elopement risk assessment when there are change in condition or new admission / readmissions. She said monitoring will also be addressed in the facility's QAPI meetings. In a telephone interview on 08/02/2024 at 3:53 PM, CNA C stated Resident #1 was standing by the bed, watching television on 07/30/2024 at about 12:15 AM. He said when he looked into the room again at 3:15 AM, the lights were off, and he assumed Resident #1 was sleeping. He said she did not physically touch or see Resident #1. He said he should go into the room and check on all residents. He said he did not because he did not want to wake them up. CNA C said he completed his shift at 6:00 AM and did not know Resident #1 had eloped. He said he was in-serviced on elopement protocol, rounding and ensuring residents are safe, and abuse and neglect policy, on 07/31/2024. He said he understood that not checking on Resident #1 placed him at risk of harm because he was able to elope and walk 8 miles before being found. In a telephone interview on 08/03/2024 at 8:15 AM, RN E stated he last saw Resident #1 about 4:00 AM on 07/30/2024 when he gave the water bolus. He said he did not check on Resident #1 after that and left the facility at 6:00 AM when his shift ended. He said he did not know Resident #1 eloped and realized there was no excuse to ensure all residents were safe and accounted for at the end of his shift. He said he was in-serviced on rounding, elopement policy, and abuse and neglect. Record review of Resident #1's MAR dated 07/30/2024 and signed by RN E at 4:00 AM, reflected, Enteral Feed Order every 4 hours related to GASTROSTOMY STATUS Bolus with 200ml of water every 4 hours for hydration and tube patency. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Provider Investigation Report, dated 07/30/2024, reflected the following: On 7/30/2024 at 7:15am, the [DON] answered the phone and [Family Member] let her know that she received a call from [restaurant employee] that [Resident #1] was lost. The DON immediately sent the van driver to pick [Resident #1] up. Once van driver arrived, he saw [Resident #1] sitting with police, van driver loaded [Resident #1] and brought him back to the facility. DON placed [Resident #1] in the secure unit; pain and skin assessment performed. No injuries and no distress when he returned. The last staff to see [Resident #1] was a nurse that documented a treatment at 4:30am. As soon as the DON was informed, she went to the [Resident #1's] room and noticed the window open and the screen push away from the room. The roommate was interviewed, and he did not see or hear anything since he was asleep. Elopement risk assessment completed for all other residents completed. Doctor was notified and in servicing initiated. The investigation was confirmed, and the following provider actions taken: In service on Elopement, Elopement Prevention QA checklist, Check the locking mechanisms or alarm is functioning properly, [Resident #1] was placed in our secure unit in a room that face an inner courtyard. On 08/02/24 at 12:30 PM, a search via AccuWeather, https://www.accuweather.com revealed the temperature on 07/30/2024 at 8:00 AM in [county], was 84 degrees F. Record review of the facility's policy titled, Elopement prevention, revised 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. 1.The Elopement Risk Assessment will be completed upon admission. The assessment should be completed by reviewing the resident's medical history and social history. Information may be obtained by reviewing current medical records, if available, interview with resident/family, or conference with the interdisciplinary team member. The assessment tool should be completed, and interventions implemented as indicated. The Elopement Risk Assessment is to be completed at least quarterly, after an elopement attempt, upon new exit seeking behavior, and upon change of condition. 2. All residents who are at risk for harm because of wandering (elopement) will be assessed by the interdisciplinary care planning team. 3. The resident's current chart and assessments will be reviewed to determine what changes have occurred that would trigger elopement episodes. 4. The resident's care plan will be modified to indicate the resident is at risk for elopement episodes. 5.Interventions into elopement episodes will be entered onto the resident's care plan and medical record. 6. Should an elopement episode occur, the contributing factors, as well as the interventions tried, will be documented in the nurses' notes. Director of Risk Management and\or Director of Nursing Services should be notified of elopement. 7. If a resident is discovered to be missing, a search shall begin immediately. (See policy entitled Elopement Response). Record review of the facility's policy titled, Elopement response, revised 10/27/2010, reflected, Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented . 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as practical. 2. Determination of missing resident either by routine nursing rounds or door alarms .7. Post return resident evaluation and care: C. The facility will evaluate its elopement prevention program and all residents will be reassessed for elopement risk. 8. Documentation: An event note is to be made out on all residents who, without knowledge of the staff, leave the facility. Including the following: Date, Time resident was first determined missing, Responsible party notified and time, attending physician notified and time, Emergency Personnel, Condition of resident when located, where located and time located. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled, Abuse/neglect, revised, 03/29/2018, reflected, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart .The facility will provide and ensure the promotion and protection of resident rights . Adverse event. An adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. A past non-compliance Immediate Jeopardy (IJ) situation was identified on 08/02/2024 at 1:40 PM. The Immediate Jeopardy began on 07/30/2024 and ended on 07/31/2024. The facility had corrected the non-compliance before the surveyor began. The facility took the following actions to correct the non-compliance prior to the investigation: Record review of the Elopement Risk assessment dated [DATE] and signed by the DON, reflected, a score of 20, Elopement risk. Record review of the facility's completed door alarms checks, dated 07/30/2024 and signed by the Maintenance Director, reflected all alarmed doors were checked and in working order. Record review of the facility's elopement risk assessment list dated 07/30/2024 and 07/31/2024, reflected updated elopement risk assessment were completed for each resident. Record review of the facility's, Elopement drill record, dated 07/30/2024, reflected, start: 7:15 AM and end: 7:30 AM. Notifications made and evaluated by the DON. Post Event Documentation Review: E1opement Risk Management Event Nurse's Note, Elopement Risk Assessment, Follow-up elopement nurse's notes. Care plan updated with actual elopement and at risk for elopement care plans. Record review of the facility's, Resident 15 min visual check sheet, dated 07/30/2024 at 8:00 AM - through 08/02/2024 at 2:15 PM, reflected Resident #1 was monitored for location and activity every 15 minutes for the time period and continues. Record review of the facility's in-service record, titled, Elopement, Abuse/Neglect, dated 07/30/2024 and administered by the DON to all staff, covered the elopement and Abuse/Neglect policies and, Walking rounds are to be conducted. At the beginning of your shift, At the end of your shift, as frequently as you can (but at least every 2 hours), Every resident must be a counted for every time you do a walking round, you must know where your residents are to keep them safe, you must have relief before you leave your shift. Interviews on 08/02/2024 from 10:00 AM to 4:00 PM with the Social Worker, Maintenance Director, HR Director, Dietary Manager, Housekeeping and Laundry Supervisor, Physical Therapist, CNAs A, B, C and D; RNs E and F; LVNs G, H, and I; and COTAs J and K, revealed they had received in-service training between 07/30/2024 and 07/31/2024. They stated the training had included how to properly secure the exit doors and reset the alarms. They were able to convey knowledge of the facility's policy on abuse/neglect and elopement policy and procedures.