

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455895	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2024
NAME OF PROVIDER OR SUPPLIER  Five Points at Lake Highlands Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  9009 White Rock Tr Dallas, TX 75238	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 27070</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the resident environment remains as free of accident hazards as is possible and that residents received adequate supervision to prevent accidents for one (Resident #1) of four resident reviewed for quality of care.</p> <p>The facility failed to ensure Resident #1 was adequately supervised to prevent her from leaving the facility unsupervised. There was a door near the secure unit that did not have an audible alarm.</p> <p>It was determined the noncompliance was identified as a Past Noncompliance Immediate Jeopardy (IJ). The IJ began on 06/01/2024 and ended on 06/02/2024. The facility corrected the noncompliance before the investigations began.</p> <p>This failure placed residents at risk for harm and/or serious injury.</p> <p>Findings included:</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 05/22/2024, reflected the resident was a [AGE] year-old-female who admitted to the facility on [DATE]. The resident had diagnoses which included: Heart Failure (disease that affects the heart muscle), Schizophrenia (mental illness), cognitive impairment (confusion) end stage renal disease (kidneys have stopped working) and, dependent on dialysis (a machine that cleanses the blood). The MDS reflected she had a BIMS score of 10, which indicated moderate cognitive impairment. The resident was ambulatory with an unsteady gait, used a wheelchair as a walker, and required assist of one staff for activities of daily living. The MDS did not reflect any wandering behavior.</p> <p>Record review of Resident #1's care plan, dated with a review date of 03/30/2024, addressed the resident's impaired cognition due to schizophrenia loss, dialysis, wandering behavior on secured unit, and assistance required for activities of daily living.</p> <p>Record review of Resident #1's clinical record revealed two Elopement Risk Assessments, quarterly elopement risk assessment dated [DATE] reflected she was score of 13 (high risk for elopement). An elopement or attempt risk assessment dated [DATE] reflected she was a score of 26 (high risk for elopement).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the Provider Investigation Report completed by the Administrator, dated 06/02/2024, revealed Resident #1 was independently ambulatory using her wheelchair as a walker, and her own responsible party. There was a family member as the #1 contact in case of emergency contact. Resident #1 could not make decisions for herself but was alert and usually understood. Resident #1 had left the facility on [DATE] sometime between 9:00 p.m. and 10:00 p.m. The resident had been located at the hospital in the ER on [DATE] at approximately 7:30 p.m. The resident was last seen sitting by one of the exits of the secured unit at some time before 10:00 p.m. on 06/01/2024. The family was notified, and the police were called. The facility staff searched for Resident #1, calling a Code Orange at 10:15 p.m. after observation that Resident #1 was missing. The family was contacted multiple times on 06/01/2024 and returned the call on 06/02/2024 at 11:45 a.m. The family stated they would call around and gave the administrator the Resident #1's last known address. The police used dog and picked up a scent at the local bus stop. The police reviewed the local bus company camera footage and the location of exit. The police contacted the administrator and informed the facility a secondary scent was picked up at the bus station in a city 4 miles away. The Provider Investigation Report reflected a finding of confirmed (for other). The facility started in-service at 12:00 a.m. on 06/02/23 on the elopement procedure policy and procedures with all staff. The facility's DON reassessed all the resident for elopement risk and updated and checked all care plans on 06/02/24.</p> <p>Review of Provider Investigation Report dated 06/02/2024 reflected a finding of confirmed for Other. Review of the External/Internal/Systemic Approach Investigation Summary dated 06/02/2024 completed on 06/02/2024 reflected: . An emergency QAPI meeting was held on 06/02/2024 with Medical Director in attendance . all residents had a new elopement assessment to identify any current patients that are imminent risk for elopement (no other residents were found to be at imminent risk of elopement) . (who was responsible: Nurse Management . who will monitor: Director of Nursing. elopement assessment will be completed upon admission and quarterly by the charge nurse and/or nurse managers and for any resident that triggers an imminent risk for elopement, the elopement response protocol will be initiated Any patient that triggers elopement risk will be placed on 1:1 monitoring until no longer deemed necessary. DON will monitor for compliance for daily times 5 days and weekly times 4 weeks until 06/30/2024 and then monthly on an ongoing basis .Who will monitor: Administrator and or designee tested the functionality of all doors (closure and alarm) and outside gates on the facility property for proper functioning and no issues were identified. Maintenance director or designee to monitor facility doors and gates checked to validate proper functioning daily times 5 days, weekly times 4 weeks , then as needed thereafter. The Director of Nursing During this interview the logs were requested form maintenance department and/or Nurse Manager will monitor weekly for compliance by completing an audit of the elopement assessments. Audits will be completed weekly for 3 weeks until 06/30/2024 and monthly on an ongoing basis Monitoring . Starting 06/01/2024 Director of Nursing and/or Nurse Managers will receive in hand, the resident monitoring/ every 2-hour body check documentation at the end of each shift for the first 72 hours, each day for one week, then weekly for 4 weeks. The Administrator will review the documentation each week for compliance Facility staff to monitor and validation for proper functioning of all doors, and gates when interruption in electricity are identified daily [NAME] 5 days, weekly times weeks then as needed thereafter when interruptions occur . Facility receptionist to conduct visitor observation for attempting to allow residents to exit facility unsupervised daily times 5 days , weekly times 4 weeks, then as needed thereafter . QAPI committee will review monthly for 3 months and adjust he plan of corrections and processes as needed. The Administrator will monitor daily to ensure compliance for four weeks and will review . Further review of the Providers Investigation Report reflected monitoring and audits by the designated staff (DON Nurse Managers) had occurred.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's nursing progress notes from 05/01/2024 until 06/01/2024 reflected Resident #1 was on the secured unit and was only signed out three times a week on Tuesday, Thursday and Saturday for pass by facility staff when she would agree to go to dialysis. The resident was ambulatory on the secured unit utilizing a wheelchair as a walker for mobility. Further review reflected without the wheelchair the resident could only mobilize safely for about 20 feet. Further review reflected Resident #1 was not exit seeking. She would go to the doors but just look out the window and never touch the door, to set off the system.</p> <p>Record review of Resident #1's progress notes reflected dated 06/01/2023 at 10:15 p.m., LVN A noted CNA B was coming back from break and then informed LVN A that she could not locate Resident #1. LVN A stated, after being informed by the CNA, conducted an additional search, and then informed the nurse manager on duty and a code orange meaning elopement was called. The code included notification of the administrative staff, responsible party, police, and the physician.</p> <p>Record Review of the elopement risk assessments reflected the DON had assessed all resident for elopement as part of the plan of correction.</p> <p>Review of the in-service dated 06/01/2024 reflected all staff attended and the subject matter was regarding Facility policy on elopement and reducing the risk for elopement: initiating a frequent monitoring form, elopement forms for new admission, and quarterly or condition change, intervention, put in place immediately with reporting to the nurse in charge, ensuring all doors are closed after exiting the unit and all doors that lead to the outside, all alarms that have been placed on doors are independently functioning and the staff knows to report and how to reset the panel for the system, and the individual alarms. During a power outage (even flickering of power) staff are to check all doors to ensure they are secured, the doors will need to be manually reset (instructions on the manually reset). Further review reflected the staff was also in-serviced on abuse, neglect, and exploitation (types of abuse and who the abuse coordinator is). There were handouts given and a test to ensure competency . The staff was instructed they could not return to work until they had the training and had passed the test.</p> <p>Review of the in-service dated 06/01/2024 was reviewed and reflected abuse and neglect test that was given to the employee after the training. The test including five question concerning abuse and neglect: (questions what identifies abuse &amp; neglect, what are you supposed to do when you observed it or told about it, who do you report, and what so you do if nothing appears to be done about the report.)</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 06/03/24 at 9:00 a.m. with the Administrator revealed had been informed by the facility of the elopement around 10:30 p.m. on 06/01/2024, arrived at facility at 10:50 p.m. The Administrator began looking for Resident #1 and had been informed the staff was divided up into internal and the external search parties. The Administrator stated the facility had sent out a mass text and a lot of staff showed up to help. There were already staff driving around the area and the neighborhood, the police had been notified. The Administrator stated police arrived just before 11:00 p.m. and the DON arrived shortly after. The Administrator stated the police had a search helicopter looking for Resident #1 and search dogs, due to area being wooded, dense, close to busy streets and the bus stop. The Administrator stated the DON started trying to contact the family. The Administrator stated when information had been provided of an address in the area where Resident #1 used to live, the facility provided the address to the police; Resident #1 was not there. The Administrator stated the facility staff, drove at different times to the address to check; Resident #1 was not there. All residents had been accounted for, except Resident #1. The police stayed in contact and informed the Administrator of the scent the search dogs had picked up at the bus stop. The police told the Administrator there was a review camera footage and the location of Resident #1's exit. The police were able to determine Resident #1 had traveled to another city near the facility and the search dogs had picked up the scent at that bus station. The search dogs could not pick up Resident #1's scent again after located the scent multiple times at the bus station. The Administrator contacted all the local hospital, called the local news station, provided a picture and details of Resident #1's elopement. The Administrator stated the in-services on the night of the elopement (06/01/24) covering the elopement process, the security alarm system for the units. The Administrator stated the staff was in-serviced on how to conduct a search, and how to manually reset the system on the secured unit, if there was a power outage or power surges. The facility staff had to come in person to in-service on the topics, including abuse and neglect. The staff had to be checked off competency before were allowed to return to work. The Administrator stated the entire staff (160) had been in-serviced. The Administrator stated there was one staff member that phone was broken and would be in-serviced on tomorrow (06/04/24) when the staff returned to work before, the staff went to work. The Administrator informed the surveyor, one of the hospitals had contacted, the facility. Resident #1 had shown up at the hospital around 7:30 p.m. (06/02/24), walked into the emergency room requesting to see a physician because of a cough. Further interview revealed later in the day on 06/03/24, the Administrator had been contacted by the hospital again. The Administrator was told Resident #1 was not injured, the doctor had run some lab work and was going to dialyze Resident #1 (even though the resident was not due until tomorrow, Tuesday) just to be on the safe side, then return the resident to the facility after completed dialysis.</p> <p>An interview on 06/03/24 with MA G at 9:15 a.m. revealed MA G only worked Monday through Friday was not working when Resident #1 eloped. MA G stated Resident #1 was a pleasant lady, but was everywhere on the secured unit, and used a wheelchair for mobility like a walker. MA G had been in-serviced on elopement. MA G had to come up to the facility on Sunday. The MA had been shown how to reset the security system manually and how the alarms on the doors functioned.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview on 06/03/2024 with Floor Tech at 10:00 a.m. revealed the Floor Tech had been cleaning the floors in the ding room of the secure unit at 7:30 p.m. The Floor Tech noticed Resident #1 sitting in the television room. The Floor Tech stated Resident #1 wanted the Floor Tech to buy a bag of chips and a soda from the vending machine. The Floor Tech had reported to the nurse Resident #1 wanted a snack. The floor tech left the unit around 8:45 p.m. Resident #1 was sitting in the doorway of room, in the wheelchair. The Floor Tech came back when the facility sent out the mass text and tried to look for Resident #1 but did not find the resident. The Floor Tech had been in-serviced on elopement process and the security system on the secured unit and the alarms on the doors and how to reset the system.</p> <p>An interview on 06/03/2024 with LVN E at 11:00 a.m. revealed Resident #1 was very pleasant, unsteady on the feet at times, walked all the time, except when was sitting at an exit and used wheelchair as a walker. LVN E stated Resident #1 was not always alert and oriented. Resident #1 required assistance of the staff to help change clothing and be reminded of when to eat. LVN E stated LVN A was working on the secured unit that night. LVN E had been contacted by phone by LVN A that Resident #1 was missing, a code orange had been called and the whole facility began a head count and started looking for Resident #1 inside and outside the facility, just like the staff had been trained to do. LVN E informed the administrative staff and the police for LVN A. LVN E stated the police had brought search dogs and the police informed the facility the dogs had picked up Resident #1's scent at the bus stop. Resident #1 had taken a bus to another area. LVN E stated on (06/02/24) the hospital had called the facility. Resident #1 had come into the ER and needed to see a doctor. LVN E stated there was no idea how she got out. LVN E had not heard any alarms go off on the unit and alarms were loud. LVN E stated the weather that night was good; it was not raining or storming. LVN E had been in-serviced on the secured unit system, how to check the doors and validate the system, how to manually reset it just in case it was needed, and the process of elopement before leaving the facility that night.</p> <p>In an observation and interview on 06/03/24 at 11:00 a.m. with Maintenance Supervisor revealed the security unit functionality of all doors (closure and alarm) and outside gates on the old unit and new unit were working appropriately. The Maintenance Supervisor had placed all new audible alarms on the doors in the old unit and the new unit. The surveyor observed those working with demonstration from the Maintenance Supervisor on the old unit and the new unit. During this interview the documents were provided for the logs on the checks of the system for the secured unit, old and new, starting on 06/02/24 and was to continue daily for 5 days a week times four weeks. The Maintenance Supervisor stated the facility had just placed an alarm on the door between the two dining rooms on 06/02/24 and explained the door was hooked up to the system and is able to reset , but that it was the only door that did not have an audible alarm on it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 06/03/2024 with CNA C at 12:30 p.m. revealed Resident #1 was very pleasant, unsteady on feet at times, but used a wheelchair as a walker. CNA C stated Resident #1 was not always alert and oriented. Resident #1 required assistance of the staff to help change clothing. CNA C had observed Resident #1 on 06/01/24 around 10:00 p.m. sitting at the exit doors, looking out the window eating chips and drinking a coke. CNA C stated Resident #1 never touched the doors and does not set off the alarms. CNA B recalled what Resident #1 was wearing, when the other CNAs came and asked if CNA C had seen Resident #1. CNA C informed CNA B, Resident #1 had not been seen and CNAs began looking. CNA C went to the new unopened secured unit and back around past the vending machines to the other side of the facility that was called A2 (a new memory care unit that has not been licensed yet for usage). There was a door between both dining areas leading off the old unit into the new dining room area. CNA C thought maybe Resident #1 had gotten through the door somehow, CNA C did not find Resident #1. CNA C looked all over the new secure unit that had not been opened. CNA C did not check the doors on the new secured unit to see if any of the doors had been left open. CNA C had been in-serviced on the secured unit system, how to check the doors and validate the system, how to manually reset it just in case it was needed, and the process of elopement before she left the facility that night.</p> <p>An interview on 06/02/24 at 12:45 p.m. with LVN D revealed LVN D had been in-serviced on the elopement process and knew what to do. LVN D did not work on the secured unit, LVN D was still shown how to check all the doors and reset the system manually.</p> <p>An interview on 06/30/24 at 1:45 p.m. with CNA F had been in-serviced on code orange and what to do when a resident elopes. CNA F was shown how the alarms work on the doors in the facility, including the secured unit doors.</p> <p>An interview on 06/03/24 at 2:30 p.m. with LVN A revealed CNA B had taken a break. After the break CNA B could not locate Resident #1 to assist her to go to bed. LVN A stated CNA B reported Resident #1 was missing around 10:15 a.m. the LVN looked for Resident #1 and could not find the resident. LVN A informed the nurse manager on duty, who was LVN E and a Code Orange was called. LVN A stated the staff all looked inside and outside, the police, administration, and responsible party were contacted. LVN A stayed with the residents on the secured unit, until the relief nurse came, then started looking again. LVN A stated the resident never verbalized anything about leaving, Resident #1 would sit and look out the window on the doors or out the window in the room. LVN A stated Resident #1 never touched the doors to set the alarms off. LVN A had been in-serviced on the alarm system and how to check the doors and validate the system, and how to manually reset, just in case it was needed and the process of elopement before leaving the facility that night.</p> <p>An interview on 06/03/2024 with CNA B at 4:00 p.m. revealed CNA B had worked at the facility off and on for the past 7 years. CNA B recalled Resident #1 she was very pleasant, unsteady walking at times, but used a wheelchair as a walker. CNA B stated Resident #1 was not always alert and oriented. Resident #1 required assistance of the staff to help change clothing, and shower. CNA B had observed Resident #1 many times sitting at the exit doors or in the room looking out the window. CNA B stated Resident #1 never touched the doors and did not set off the alarms. CNA B stated Resident #1 would talk about checking on her child but would not talk was leaving. CNA B had been in-serviced on the secured alarm system on the doors. CNA B had been shown how to check the doors and validate the system. CNA B was shown how to manually reset the alarms, and the process of elopement before she left the facility that night.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Five Points at Lake Highlands Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  9009 White Rock Tr Dallas, TX 75238	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility's Policy and Procedure Elopement Response, dated January 2023, 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 premise, 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: 4. Should an employee discover the resident is missing from the facility (Code Orange), he/she should charge nurse, . C. Make a thorough search of the building and premises . D. notify the Administrator and the Director of Nursing . E. Notify the responsible party . F Notify the attending physician .H. if necessary, notify . agency . J. make and extensive search of the surrounding area.5. A. Charge nurse on each unit send staff down each hall to check each room, including bathroom, closet, and bed for correct resident 6. A. Charge nurse designates one CNA per hall to remain on unit along with him/herself and sends remaining staff to affected area. B. Charge Nurse assigns staff to specific outside areas to ensure that all surrounding areas are searched C. after 30 minutes , if the resident had not been found, the following call must be made: report missing resident to the police .update all administrative staff Secured Unit. Fire exit doors on the secure unit will meet the following criteria: lock must be electro-magnetic, the lock must release when one of the following occurs: the fire alarm or sprinkler system are activated, power failure to the facility, activation of a switch or button located at the monitoring station and the main nurse's station</p>		