

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455962	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER Kaufman Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 S Houston St Kaufman, TX 75142	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #1) of 5 residents reviewed for elopement risk.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility and cross a four-lane highway 04/24/2024.</p> <p>The noncompliance was identified as PNC. The IJ began on 04/24/2024 and ended on 04/24/2024. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place all 5 residents who used a wander guard at risk for serious injuries.</p> <p>The findings included:</p> <p>Record review of the face sheet, dated 08/06/2024, revealed Resident #1 was an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included unspecified dementia (a general term for impaired ability to remember, think, or make decisions), altered mental status (a change in mental function), cognitive communication deficit (trouble reasoning and making decision while communicating).</p> <p>Record review of the comprehensive care plan dated 03/08/2024, revealed Resident #1 was a risk for elopement due to his diagnosis of unspecified dementia. The care plan goal, initiated on 03/09/2024 I will not elope from the center in the next 90 days. The care plan interventions included, When I begin to wander, provide comfort measures for my basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). Problem start date 04/24/2024 edited on 04/24/2024, I have had an elopement event. The care plan goal, I will not elope from the center in the next 24 hours, at which time I will be transferred to secure unit facility. The care plan interventions included staff will monitor me 1:1 until I am transferred to the secure unit facility.</p> <p>Record review of the MDS assessment, dated 03/11/2024, revealed Resident # 1 had a BIMS score of 06, indicating severe cognitive impairment. MDS assessment for wandering behaviors coded as a 1, indicating Resident #1 had the potential to wander. MDS assessment did not address transfer to secure facility on 04/24/2024.</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 order summary dated 03/01/2024, revealed Resident # 1 had an order for a wander guard and verify placement every shift with a start date 03/09/2024 and end date 04/24/2024.</p> <p>Record review of the Elopement assessment, dated 03/09/24, revealed Resident #1 was at risk for elopement at this time. Proceed to potential interventions and care plan.</p> <p>Record review of the progress notes dated 04/24/2024, by DON revealed Resident #1 was placed on 1:1 observation at 7:20 a.m. after elopement. Resident # 1 sitting on couch in common area watching a movie. Resident #1 stated he had no pain. Resident #1 was smiling and laughing with staff. Resident #1's wander guard was on and in working order. Resident # 1 was taken to his room for head-to-toe assessment by floor nurse and returned to the couch in common area per his request to watch a movie. Resident #1 continued with 1:1 observation. 8:25 a.m. Resident #1 had continued 1:1 observation since return to the facility. Resident #1 continues to deny pain and no apparent injury. Progress notes did not address transfer to secure facility on 04/24.2024.</p> <p>Observation of the facility grounds on 08/05/2024 at 10:15 a.m., revealed the facility was located along side and facing a two-lane farm to market road. Observation upon approaching the facility revealed the front door to be locked and a keypad present without an access code posted. Surveyor rang the doorbell and was let inside by staff member. The front door had a delayed egress bar, keypad and a wander guard system.</p> <p>Observations of the facility on 08/05/2024 at 3:47 p.m., revealed exit doors at the end of each of the 4 hallways had a delayed egress bar, STOP alarm box in the armed position and a code alert box. A sign was on the door stating the alarm will sound for 15 seconds then door will open. Exit door alarms sounded when the surveyor pressed on the delayed egress bars at all exit doors. Surveyor observed signs posted on each of the 4 doors, door not in use.</p> <p>Observation on 08/05/2024 at 4:15 p.m. of the facility grounds and route Resident #1 traveled to exit the facility to the location he was found, revealed Resident #1 walked approximately 0.6 miles from the exit door, through the parking lot and across the highway where he was found at a convenience store.</p> <p>During an interview on 08/5/2024 at 1:04 p.m., Resident #1's family member stated the facility called 04/24/2024 after 9:00 a.m. stating Resident# 1 had gone outside by himself, and the police found him at the convenience store. Resident #1's family member stated the facility told her he got out before breakfast and went to the convenience store. Resident #1 family member stated she did not know how he got out with the bracelet on his ankle. Resident #1 family member stated she agreed Resident #1 needed to be transferred to a secure facility and the facility had him 1:1 one until he was transferred to another facility with a locked unit that day.</p> <p>During an interview on 08/5/2024 at 5:15 p.m., CNA A stated upon arriving to the facility on [DATE] at 7:01 a. m. she received a call from the sheriff's department stating Resident #1 was at the convenience store. CNA A stated she got into the van and went to get Resident # 1 and was back at the facility by 7:20 a.m. CNA A stated she notified the Administrator immediately. CNA A stated it was everyone's responsibility to make sure the resident did not elope. CNA A stated it was important to prevent elopement for the safety of the residents. CNA A stated the harm was the residents could get injured. CNA A stated she was in-serviced on missing residents, elopement and not to use the side doors for an exit 04/24/2024.</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>During an interview on 08/05/2024 at 6:11 p.m., LVN B stated Resident #1 would wander the halls but was easy to redirect. LVN B stated she last saw Resident #1 in his room before her shift was over at 6:00 a.m. LVN B stated they checked resident's wander guards on night shift and Resident #1's was working. LVN B stated they could check the wander guard by walking the resident to the door or they have a machine on the nurse cart to check the wander guards. LVN B stated it was their responsibility as caretaker to make sure the residents were in the facility and safe. LVN B stated the harm could be injury or death. LVN B stated she was in-serviced on missing residents, elopement and not to use the side doors for an exit 04/24/2024.</p> <p>During an interview on 08/07/2024 at 2:55 p.m., the DON stated they were not sure which door Resident # 1 went out. The DON stated Resident #1 was not out of the facility for long. The DON stated Resident #1 could not remember how he got out of the facility. The DON stated the side doors were locked and the staff cannot use them anymore. The DON stated all the staff were responsible for making sure the residents remain in the building. The DON stated it was important the resident stay in the facility to ensure their safety. The DON stated the potential harm to Resident #1 was he was not safe without supervision. The DON stated she had held an in-service on 04/24/2024 on missing residents, elopement and not to use the side doors for an exit.</p> <p>During an interview on 08/07/2024 at 3:04 p.m., the Administrator stated she thinks Resident #1 got out on Hall 300 because of a delay in the door. The Administrator stated Resident # 1 was not out of the facility for long. The Administrator stated Resident # 1 was not any distress when he returned to the facility. The Administrator stated the door was fixed the day of the incident and staff can no longer use the side doors. The Administrator stated it was a team effort to ensure the residents remain in the facility. The Administrator stated it was important to ensure resident remain in the building, so they do not get hurt. The Administrator stated the harm was Resident # 1 could have fallen or hurt himself.</p> <p>During an interview on 08/07/2024 at 3:09 p.m., the Maintenance Supervisor stated he was not aware the door on hall 300 had a delay in locking until Resident # 1's elopement and the door was repaired the same day. The Maintenance Supervisor stated all the staff were responsible for ensuring Resident # 1 remained in the facility. The Maintenance Supervisor stated it was important because it was unsafe for Resident #1 to be outside of the facility unsupervised. The Maintenance Supervisor stated the harm was Resident #1 could have been injured.</p> <p>Record review of a facility's Wandering and Elopement policy revised 09/01/2023, indicated The facility will ensure that residents who exhibit wandering behavior and/ or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Elopement occurs when a resident leaves the premises or safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so,,,,, Monitoring and managing residents at risk for elopement or unsafe wandering Adequate supervision will be provided to help prevent accidents or elopement</p> <p>The facility course of action prior to surveyor entrance included:</p> <p>Record review of the Administrator's PIR, dated 04/24/2024, revealed an investigation was initiated on 04/24/2024 and all required notifications were made which included the responsible party, and physician.</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 an in-service dated 04/24/2024, topic: Missing Residents / Elopement, description: CODE PINK was the code for a missing resident. Upon suspected elopement, unable to find a resident, staff will call a CODE PINK. The charge nurse will direct staff appropriately: 1-2 staff would go outside and check the perimeter of the facility, the remaining staff will conduct methodic search of every resident room, restroom, every unlocked door in the entire facility. The in-service was signed by 43 employees.</p> <p>Record review of an in-service dated 04/24/2024, topic: Exit Doors, description: staff are not to give door codes to families except to the front door. When giving door code to family, educate them not to share the code with anyone. They must abide by the rule of not saying or displaying the door code just as staff are mandated to keep these codes for staff only. They must comply to maintain this privilege. Staff are not to say the door codes out loud, in earshot of, or by visual display to/near non-staff persons. Staff are to ensure that upon entering or exiting the building that the door is fully closed and secured. The in-service was signed by 43 employees.</p> <p>Record review of an in-service dated 04/24/2024, topic: Abuse, Neglect, and Exploitation, description: all suspected, alleged, or actual abuse was to be reported immediately to the Abuse Coordinator, who is the Administrator. If for some reason staff are unable to reach the Abuse Coordinator, they are to notify the Director of Nurses. The in-service was signed by 42 employees.</p> <p>Record review of an action plan dated 04/24/2024.</p> <p>Intervention: Elopement Prevention, Action: Educate on Elopement.</p> <p>Intervention: Door Delay, Action: Service contractor needs to be called to check doors. Comments: 4/24/2024 Service Contract Representative came to the facility and checked the doors. The doors had a delay which was fixed immediately.</p> <p>Intervention: Door Checks, Action: Weekly door checks were to be completed. Comments: Maintenance completed more than weekly door checks.</p> <p>Record review of weekly door checks with a start date of 04/24/2024, revealed an exit door on hall 300 had a time delayed issue. Service Contract Representative came to the facility and checked the doors. The doors had a delay which was fixed immediately. No other issue with weekly door checks.</p> <p>04/25/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>04/26/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>04/29/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>04/30/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>05/01/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>05/02/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>05/06/2024 doors on hall 100, 200, 300 and 400 passed check.</p> <p>(continued on next page)</p>

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