STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675000	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Beechnut	12777 Beechnut St Houston, TX 77072

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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	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** 44591 Based on observation, interview, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent elopement for one of twenty-one residents (Resident #1) reviewed for accident hazards and supervision. -The facility failed to ensure Resident #1 had adequate supervision on 8/16/2024 which allowed her to elope from the facility. She was not found until 8/17/24 when she was admitted to the emergency room with complaints of heat exhaustion and weakness. The noncompliance was identified as past noncompliance and the Administrator was given the IJ Template on 8/29/24 at 2:23 pm. The IJ began on 8/16/2024 and ended on 8/18/2024. The facility had corrected the noncompliance before the investigation began on 8/18/2024. These failures could place residents at risk of serious injury or harm. Findings include: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included schizophrenia (is a serious mental health condition that affects how people think, feel and behave), cognitive communication deficit (difficulty with communication that is affected by disruption of cognitive process), bipolar disorder (mental health condition that causes extreme mood swings), blindness right eye. Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS score of 03 indicating severe cognitive impairment. The MDS documented she had no potential indicators of behaviors affecting others, or rejection of care. Per the MDS, Resident #1 did not have wandering behaviors daily during the review period. The MDS documented she required supervision or assistance with all ADL's. Record review of Resident #1's Care plan initiated on date 4/18/2024 revealed her risk for wandering and risk of elopement, with her having a wander guard. The care plan included a focus on her interventions including identifying triggers for wandering/eloping, implement toileting program, monitor resident frequently, reorientate to surroundings/environment. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1' s nurse's note dated 8/16/2024@ 23:21 revealed she could not be found in her room, the facility was searched and she was not found. The resident was last seen at 6:30 pm during dinner as reported by the CNA C. Code pink for missing person was initiated. Other staff began searching outside the facility and some staff began driving around the neighborhood. Around 9:00 pm the RN A reported to the Administrator and Director of Nurse that resident was not found. Administrator and Director of Nurse began to search. RN A notified the family, 911 and Houston Police Department (HPD) around 9:30 pm. HPD arrived within minutes and necessary information to file a missing person was given to HPD. Search areas included gas station, bus stops, homeless spots in the area, hospitals called and visited, Metro bus station center notified. Record review of Resident #1' s nurse's note dated 8/17/2024@ 18:46 revealed DON visited the resident in the hospital after being notified by the police she was at the hospital. Resident was asleep and the hospital nurse reported the resident was stable and receiving IV fluids, no injuries were noted or reported during admission full body assessment. Record review of Resident #1' s elopement risk assessment dated [DATE] revealed she was an elopement risk of 2.0. Record review of Resident #1' s elopement risk assessment dated [DATE] revealed she was an elopement risk of 5.0. Record review of Resident #1' s elopement risk assessment dated [DATE] revealed she was an elopement risk of 2.0. Record review of Resident #1' s elopement risk assessment dated [DATE] revealed she was an elopement risk of 8.0. Record review of Resident #1' s elopement risk assessment dated [DATE] revealed she was an elopement risk of 14.0. Record review of hospital records dated 8/19/2024 revealed she was received in Emergency Dept 8/17/24 via ambulance, with complaints of heat exhaustion, weakness, had anklet on, was poor historian was A&Ox2. She received X-Ray of chest \- Impression: no acute abnormality. Complete Blood Count (CBC) has no acute findings. Pre-hospital Fingerstick blood glucose 181 Wording to https://www.wunderground.com/ the temperature 8/16/2024 between 6:00 pm -12:00 midnight was 96-84 degrees Fahrenheit Wording to https://www.wunderground.com/ the temperature 8/17/2024 between -12:00 midnight -12:00 noon was 84-94 degrees Fahrenheit (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/18/24 2:05 pm with Administrator, said his primary duties were to manage the overall operation of the facility. The Administrator said on 8/16/2024 he received a report Resident #1 was not found. The Administrator stated somewhere between 6:30 pm and 8:00 pm when the CNA C reported the resident had not eaten dinner and was not in the bathroom. CNA C reported to RN A that resident was not in her room. Search ensued. Resident was wearing wander guard. Administrator called the HPD at 9:30 to report resident missing, also called medical director, physician, family, ombudsman. Administrator and DON went to local hospital and gave information to hospital staff with resident #1 name and date of birth, with facility phone number. The Emergency Medical Services (EMS) found Resident #1 wandering on the street, she was well dressed, did not look homeless, and was taken to hospital for evaluation. Resident remains there. The facility has tested all wander guard system are currently testing daily for 30 days. When the resident #1 arrives from the hospital her wander guard would be tested to assure that it is functioning properly. Administrator stated he did not know how resident left the building, stated it could have been a staff, a resident accidentally pressing an emergency door release button on the wall or recent power outages that may have released the alarm system throughout the facility which released all the doors allowing her to elope. The Administrator said facility has had so many power outages or surges that he has the energy company alerts on his phone. The Administrator said Resident #1 often wants to go home or wants to visit her family member, but she cannot due to her diagnoses and needs. Administrator said after the incident, all residents were assessed for an elopement risk, monitoring of all resident with wander guards are being checked every shift, and Resident #1 will be provided with a room in the memory care side when she returns. Observation on 8/18/2024 at 2:50 pm revealed the exterior doors on the 100 and 200 halls were locked and unable to be opened without using the push bar. The doors had a keypad near them to allow exit. Both doors had a sign that said an alarm would sound if they were opened without the code. Interview on 8/18/24 4:00 PM with DON, she reports the administrator called her around 8:00 pm on 8/16/2024 stating that he was on the way to the facility. It was reported to her that CNA C had given resident #1 the dinner tray around 6:30 pm resident #1 at the time of receiving the tray was on her way to the restroom. CNA C went back to see if Resident #1 had started eating and saw that the tray had not been touched. CNA C went back to resident #1's room about 20 minutes later to pick up trays and saw that Resident #1 was not there and the tray had been untouched. CNA C went to the smoking area, looked in the dining room, reported to her charge nurse, RN A the resident could not be found. RN A then notified over the speaker code yellow and all staff started searching for resident. RN A notified administrator . RN A and 2 CNA's drove around the neighborhood, RN A called the police and gave them picture with pertinent information. RN A also called family, doctor and medical director. DON started searching the field in the back of the building and inspected the ditch, church schoolyard, facility van, bus stops. The administrator searched from Hwy. 6 to facility and DON search from facility to Beltway 8 by car. Administrator called metro police, administrator went to two local hospitals to inform them of resident missing. DON and administrator then searched the facility again. Police were notified and missing report was given. DON states the police called her on 8/17/2024 around 3:00 PM that resident had been found at Hosptial. Hospital nurse gave report regarding Resident#1 she was unharmed, however, was dehydrated, was receiving IV fluids, Chest X ray and urinalysis performed. DON stated she went to see resident in the hospital. DON states when the resident comes back from hospital she will be placed in the secure unit. DON reports testing of the residence that have wander guards are tested at each of the doors 8/16/24 and 8/17/24. Staff are continuing to test each shift all doors and wander guards. Management staff testing doors and wander guards daily. All residents have been reassessed for elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/28/24 at 4:19 pm with LVN B. She stated she was working the 6:00 AM to 6:00 PM shift on 08/16/2024 on the B station which is 200 hall. LVN B reports between 5:00 PM and 6:00 PM she went to the dining room to assist with feeding residents and checking menus. LVN B visualized Resident#1 in her room prior to going to the dining room at around 5:30 PM. Resident#1 was sitting on her bed. During shift she monitored the resident's wander guard and noticed that it was blinking green meaning the battery was good. She said CNA C stayed on the 200 hall monitoring residents that did not go to the dining room. LVN B stated at around 6:30pm she gave report to RN A the oncoming nurse for 6P to 6A shift. Around 6:30 pm, CNA C asked where Resident #1 was. At that time the search began in the facility in the smoking area, closets, bathrooms. LVN B got into her car and started driving around local roads. LVN B stated she searched for two-three hours. Facility was being searched and the outside parking lot and field area. LVN B did not recall having heard any alarms during her shift and did leave the facility between 9:00 pm and 10:30 pm, the police, administrator, DON was present at that time. LVN B stated she has never had a resident elope during her career in this facility, LVN B stated she sees the maintenance manager checking doors. She also checked residents with the wander guard during her shift. CNA's and nurses check daily. LVN B stated when the wander guard flashes green and is close to the door the alarm system is working. Interview on 8/28/24 at 4:37 pm with CNA C. She typically works the 2:00 PM to 10:00 PM shift. CNA C stated resident's wander guards were checked daily to see if the green light flashes when the resident gets close to the door by staff. On 8/16/2024 CNA C stated she saw Resident # 1 in her room when she brought dinner tray and again when passing trays. Resident #1 was going into her restroom. When CNA C went to pick up dinner tray CNA C stated around 7:00 PM she noticed resident wasn't present. CNA C started checked the room, bathroom, common areas and didn't see Resident #1 and reported to RN A. CNA C reported all staff started searching. CNA C stated the administrator and DON got to the facility around 8:00 PM, the police showed up around 10:00 PM. CNA C stated she was informed on the 17th when she arrived for her shift that resident was safe. Interview on 8/28/24 at 4:51 with CMA. CMA stated she was working station B on 8/16/2024, approximately 5:30 pm to 6:00 pm and gave Resident #1 medications and a banana. When she left Resident #1 ' s room, resident was eating the banana. CMA stated she was told by a nurse around 8:30 to 9:00 PM that resident was missing, and CMA stated she started searching the parking lot, walked around the building, other staff searched by car. CMA stated she saw administrator and DON around 9:30 pm, the police were there between 9:30pm and 10:00pm, CMA stated she left around 10:00 PM. She said she felt bad when she found out Resident #1 was missing. She does not know how Resident #1 could have gone missing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/28/24 at 5:50 pm via telephone with RN A. RN A reported he received shift report at 6:00 PM on 8/16/2024 and did see Resident #1 at that time, he reported CNA C also saw Resident #1 around 6:30 PM when she was setting up the table for the resident to eat, and that Resident #1 was going toward the restroom. RN A reported when CNA C went to pick up the tray she noted that Resident #1 was not present. RN A stated he did not hear any alarms go off between 6:30 PM and 8:00 PM. He called a code yellow after realizing resident was not in the facility and got into his car and drove around the neighborhood. RN A reported he called administrator, family, physician, medical director and police. RN A stated when he spoke with Resident #1 ' s, family member and she wanted to know why he was calling. RN A reported he explained the current situation and the family member stated she had not seen Resident #1. RN A reported he kept the family member informed during the search he called her around 8:00 pm, 12:00 PM and 6:00am. RN A stated he felt horrible, when he realized Resident #1 couldn't be found. RN A stated he found out Resident #1 was at the hospital on 8/17/2024 by text. RN A stated all staff members knew what to do, were very concerned about residents welfare, had no idea how Resident #1 left the facility. Observation on 8/18/24 at 4:30 pm with administrator the wander guard alarm at the nurse station, it is a grey box with 2 blue boxes that will show which exit is being breached. Monitored the functionality of wander guard and proximity which alarm goes off appropriately. Observed staff monitoring and walking toward door that alarmed. 8/19/24 Upon entry to facility, the front door alarm went off -noted resident with wander guard close to entrance. Within 30 seconds noted 3 staff members going to front door to assess if resident was close to or outside the door. Interview on 8/28/24 at 9:30 am with Administrator, stated he had outside vendor install new sensor at the front door, the front door had been enhanced with an additional motion guard along with wander guard alarm sensitivity increased. Administrator stated each device has its own power source so no interference can occur. Administrator stated all the alarms are being monitored and tested daily by him and the maintenance director, stated they are adjusting the sensitivity and all systems are working well. The Administrator said the staff have been provided training to ensure that any time the electricity as to go out the staff immediately check and reset the doors. Interview on 8/28/24 at 10:00 am with DON, she stated she was notified by the Hospital at on 8/17/24 at 3 pm resident was there and having tests provided to her. She stated the resident told the nurse resident was looking for her family member and was found close to I 45 near downtown under a bridge at 1:00 pm by EMS. EMS provide care, then took her to hospital. The nurse in emergency department called the police and found the resident was missing person from the facility. She states training has continued, immediate response from her team when the alarm sounds continues to be her expectation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 8/28/24 at 10:30 am with Maintenance manager. States all of the wander guard alarms we're functioning and are currently functioning. He monitors them the weekly. Observed his binder with weekly door monitoring checks to include 8/16/24. Maintenance manager stated he did not know how resident could have left the building, however, there have been a lot of power outages and power surges since the hurricane. Maintenance manager stated outside vendor has added new sensor on the front door. Maintenance manager stated the front door has had an additional sensor and he is monitoring the sensitivity and adjusting it for distance. Front door, laundry door, side door by nurse station are all with key code pad a resident could leave without sounding the alarm These doors all have functioning wonder guard alarms and key code pad combination. He states he will continue to observe and adjust sensitivity for the next 30 days, then go back to monitoring weekly. Observation on 8/28/2024 at 11:55 am front door and side door at nurse station B were tested and alarm did sound appropriately. Observation on 8/28/2024 at 12:00 pm revealed the exterior doors on the 100 and 200 halls were locked and unable to be opened without using the push bar. The doors had a keypad near them to allow exit. Both doors had a sign that said an alarm would sound if they were opened without the code. Observation on 8/28/2024 at 12:10 pm Elopement binder from nurses station A,B and C to include Missing Resident Profile with resident face sheet, name, height, weight, race, color of eyes, identifying marks, device used, language, mental condition, name of friends or relatives, per their Elopement Risk Assessment Policy. Interview on 8/28/24 at 1:05 pm with family member. She stated she was not concerned at this time with the facility, feels like they keep resident safe, have been attentive to her needs since she was admitted . Interviews 8/28/24 with LVN B, CNA C, CMA, RN A reporting they were given in-services regarding elopement and could describe in detail the process for all alarms on doors, supervision of all residents. Record review of the facility's Provider Investigation Report (PIR) dated 8/17/2024 for Intake ID 525841 revealed Resident #1 had exited the facility between 6:50 pm and 8:00pm on 8/16/2024. Search of building and surrounding area started immediately. Family, physician, medical director and police contacted. Police were given photograph and other identifying information. Administrator and DON joined in search of gas stations restaurants in local businesses. Transit Authority contacted by administrator and photograph and other identifying information provided to them. Administrator also visited local hospital emergency room between 11 and midnight. Facility staff continued to search the neighborhood and local hospitals into the morning. Resident located and was undergoing assessment at hospital. No preliminary injuries reported. Staffing in-serviced on the elopement policy, elopement binder, wander guard use. 100% Elopement assessment completed on 8/17/24. All wander guards in use assessed 100% operation. Record review of the facility's invoice dated 8/20/2024 revealed the alarm servicing contractor made an inspection of wandering system and adjust as needed. Added external power supply and added a door extender to increase the detection range of the front door. Made adjustments to the gain of the existing units including the side door with LC 1200 Door Extender. Doors are fully functional. (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 in-service documentation dated 7/19/2024 revealed the staff who attended were instructed on resident elopement responses, and the facility environment. The documentation was signed thirty-three staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's in-service documentation dated 8/16/2024 revealed the staff who attended were instructed on resident elopement responses, and the facility environment. The documentation was signed thirty-eight staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's in-service documentation dated 8/17/2024 revealed the staff who attended were instructed on resident elopement responses, and the facility environment. The documentation was signed thirty-six staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's in-service documentation dated 8/17/2024 revealed the staff who attended were instructed on resident abuse and neglect. The documentation was signed by twenty-seven staff including LVN's, CNA's, housekeeping staff, dietary staff, therapy staff, social services staff, and activities staff. Per the documentation, the in-service covered the facility's elopement policies. The documentation was signed by thirty-six staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's in-service documentation dated 8/18/2024 revealed the staff who attended were instructed on resident elopement responses, and the facility environment. The documentation was signed by twenty staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's in-service documentation dated 8/27/2024 revealed the staff who attended were instructed on resident elopement responses, and the facility environment. The documentation was signed by twenty-three staff members. Per the documentation, the in-service covered the facility's elopement policies. Record review of the facility's Elopement Risk Assessment policy effective 11/01/2019 revealed a policy statement which read the community will assess all patients/residents for elopement potential in order to provide a safe and comfortable living environment. (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 Elopement Policy policy effective 11/01/2019 revealed a policy statement which read To safely and timely redirect patients/residents to a safe environment. A prompt investigation and search will be conducted if a patient/resident is considered missing. Elopement drill will be held quarterly. Procedure 1. Once it has been established that a patient/resident is missing, the following staff members are notified immediately: the charge nurse, Executive Director of Operations, Director of Clinical Operations and social service designee, responsible party and the primary care physician. Complete the missing resident profile make note of the outside temperature. 2. The director of clinical operation or designee organizes and institutes an immediate and thorough search of the center and surrounding grounds. Conduct a head count of each unit. Including but not limited to a search of the area outside the nearest exit to the patient's/resident's room or exit where he/she was last seen, and the entire unit where the patient/resident resides or was last scene, the remainder of the facility, all rooms, closets - including storage facilities - bathrooms and grounds, extending beyond the fence line. Check all offices and any locked doors to ensure none were left unlocked. 3. The entire search process of the facility and grounds, from the time the patient/resident is missing, should be completed within 30 minutes. 4. If the search fails to locate the missing patient/resident within two hours from the time the patient/resident is found to be missing, the Administrator and or designee contacts the appropriate community agencies (local law enforcement) and update the patient's/ resident's legal representative. Staff will provide the police with all physical identifying information including but not limited to physical appearance, height, weight, age, sex, and clothing. If known. 5. The search is continued period two staff members searched the surrounding streets by car for a two (2) mile radius around the facility. 6. When the patient slash resident is located, the nurse completes a head to toe assessment. The social service designee assesses the patient/resident for emotional distress. The charge nurse reports any findings to the Director of Clinical Operations. The Director of Clinical Operations notifies the Executive Director of Operations or designee and notifies the appropriate community agencies, attending physician and patient's resident's legal representative. 7. If a resident is not located during the search of the facility, facility grounds, and immediate vicinity, and there are circumstances that place the residence health, safety, and or welfare at risk, a report to HSC must be made as soon as the facility becomes aware the resident is missing and cannot be located. Examples include, but are not limited to: -a resident requires medication that, if not taken as scheduled, place the resident at risk of serious illness or death or both; -extreme weather conditions exposed to the resident to potential freezing, heat prostration, or drowning from flooding; -a resident is confused or otherwise incapable of assessing potential danger; -there is a suspicion of foul play