STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675105	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing and Rehabilitation	1900 N Frances St Terrell, TX 75160

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** 45879 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 and assistance devices to prevent elopement for 1 of 5 residents (Resident #1) reviewed for accident hazards and supervision. 1. The facility failed to ensure Resident # 1 had adequate interventions to prevent elopement on [DATE] after he had verbalized and or attempted to leave the facility on [DATE], [DATE], [DATE], and [DATE]. 2. The facility failed to prevent Resident #1 from eloping from the facility on [DATE]. Resident #1 wheeled himself approximately 0.3 miles from the facility. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 5:51 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of serious injury or harm. Findings include: Record review of Resident #1's face sheet, dated [DATE], reflected Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #54 had diagnoses which included Dementia (loss of memory), stroke, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and seizures. Resident #1 was his own responsible party. Record review of Resident #1's comprehensive care plan dated [DATE], reflected Resident #1 had behavior issues because he would decide at times that he wanted to leave the facility and go homeless. Resident #1 was educated on safety and allowed to vent and express his frustrations. Resident #1 attempted multiple times to exit the building. Resident #1 voiced he wanted to leave. The staff interventions were if reasonable, to discuss the resident's behavior. Explain/reinforce why the behavior was inappropriate and/or unacceptable and praise for any indication of the resident's, progress/improvement in behavior. (continued on next page)

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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's quarterly MDS assessment, dated [DATE], reflected Resident #1 understood and was understood by others. Resident #1's BIMS score was 03, which indicated he was severely cognitively impaired. Resident #1 required assistance with bathing and was independent with toileting, personal hygiene, transfer, dressing, bed mobility and eating. Record review of Resident # 1's Elopement assessment, dated [DATE], reflected Resident #1 was at risk for elopement. Record review of the progress noted, dated [DATE], written by LVN A, reflected Resident #1 attempted to leave the facility twice. He was redirected and brought back to the lobby. Record review of the progress noted, dated [DATE], written by LVN A, reflected Resident #1 attempted to leave the facility by the emergency exit on hall 500 when he was stopped by a CNA. He was later seen crawling toward the front door to leave the facility. LVN A notified the NP, DON, and Administrator and obtained orders to send him to the hospital. Record review of Resident #1's hospital visit, dated [DATE], reflected Resident #1 had a diagnosis of altered mental status (a disruption in how your brain works that causes a change in behavior). Record review of the progress noted, dated [DATE], written by LVN A, reflected Resident #1 was on the floor crawling toward the front door again after the hospital visit. Record review of Resident # 1's Elopement assessment, dated [DATE], reflected Resident #1 was at risk for elopement. Record review of the progress noted, dated [DATE], written by LVN A, reflected Resident #1 said he was going to leave the facility. Record review of an incident report, dated [DATE], written by LVN C at 5:52 p.m., reflected the MDS nurse was driving by the facility and noticed Resident #1 was in his wheelchair in the parking lot of the shopping center a few hundred yards away from the facility. LVN B and the MDS nurse assisted Resident #1 back to the facility. According to LVN B Resident #1 was last seen in the dining room eating supper about 20 minutes earlier. Record review of the progress noted, dated [DATE], written by LVN C, reflected she notified a family member of Resident #1's elopement and the family member stated she knew he had been trying to escape for over a month now. Record review of Resident #1's comprehensive care plan, dated [DATE], reflected Resident #1 was at risk for wandering related to history of attempts to leave the facility and voiced he wanted to leave the facility. Resident #1 tore the gate in the fenced-in smoke area and propelled himself about a block from the facility where staff observed him and assisted him back to the facility. The intervention was to place Resident #1 on 1:1 monitoring, apply a wander guard, and distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Resident #1's care plan did not address Resident #1's risk for elopement prior to [DATE]. (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 consolidated physician orders, dated [DATE], reflected Resident #1 to have a wander guard for wandering and staff to monitor every shift for the function of the wander guard. Resident #1 did not have an order for a wander guard before he eloped on [DATE]. Record review of Resident #1's electronic medical record, dated [DATE] through [DATE], did not reflect any documentation of changes in his condition that could have caused Resident #1 to make statements or attempt to leave the facility. Resident #1's electronic medical record did not reflect any interventions to prevent elopement except for redirection prior to his elopement on [DATE]. During an interview on [DATE] at 1:06 p.m., the RCN said she was the traveling DON and started with this facility on [DATE], and Resident #1 eloped on [DATE]. She said she was in the facility on the day Resident #1 had eloped. She said she left the facility before he eloped. She said staff called her at home to notify her of his elopement and they had located him and brought him back to the facility with no visual injuries noted. She said Resident #1 escaped out of the 400 hall exit door. She said the way he broke the door; the alarm did not go off to alert staff. She said she was amazed at how he escaped, she said he was determined by the way the door looked. She said she was unaware of any statements Resident #1 made before his elopement. She said she saw where he had a lot of falls according to the fall log and was trying to find out why. She said she had ordered labs, talked with the NP, and asked the pharmacist to review his medication. She said it was only after his elopement that she looked further into his medical records and realized he did not have sufficient documentation in his chart to show what the facility had done to prevent his elopement. She said she wrote orders for his wander guard and called the psychiatrist. She said he had a telehealth visit with the NP psychiatrist on [DATE]. She said the staff had already implemented the 1:1. She said they continued 1:1 until he was discharged from the facility on [DATE]. During an interview on [DATE] at 2:36 p.m., the MDS nurse said she was on her way home from the store when she noticed Resident #1 between the facility and the shopping center. She said she called the facility, spoke with LVN B, and told him what she saw. LVN B said he was not aware Resident #1 had left the facility. She said she parked her car and by then LVN B was outside of the facility. She said by the time she parked her car Resident #1 was in the shopping center parking lot a few hundred yards away. She said she and LVN B brought Resident #1 back to the facility. She said he did not have any injuries but was laughing and said he was going to leave again. She said she was aware of his threats to leave the facility and his going to the front door and pushing on the door. She said she did not think he was serious because he would wait until staff was around and then make the statement he was going to leave. She said I thought he did it more for attention. She said she had not care planned his attempts or statements of elopement before he eloped. She said she thought it was a behavior and had care planned his behaviors. During an interview on [DATE] at 3:16 p.m., the Psychiatrist NP said she had been seeing Resident #1. She said she knew he had behaviors but was not aware of his statements or attempts to leave the facility. She said they called her after he eloped on [DATE] and she did a telehealth visit (online doctor's visit) on [DATE]. She said her husband had been sick and she had missed the last few scheduled visits for Resident #1. She said she missed his [DATE], [DATE], and [DATE] visits. She said if she had known about his statements or attempts to leave the facility, she could have changed her visits, done a telehealth visit, or made medication adjustments. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:15 p.m., LVN A said she was aware of Resident #1's threats and attempts to leave the facility. She said she notified the Administrator, DON, and NP about most of Resident #1's attempts to leave the facility but was not sure about all his attempts. LVN A said on some occasions she was instructed to send him to the hospital but on other occasions, she monitored him closely. LVN A said she had not completed and did not know she needed to complete an elopement assessment, place him on every 30-minute checks, or update his care plan when he attempted to leave or made threats that he wanted to leave the facility. LVN A said Resident #1 could have injured himself on the uneven road or even died if a car had hit him. During an interview on [DATE] at 5:30 p.m., LVN C said she was the charge nurse when Resident #1 eloped on [DATE]. She said the MDS nurse notified her that Resident #1 was outside the facility between the facility and the shopping center. She said she was not aware Resident #1 had left the facility grounds. She said when she went outside LVN B and the MDS nurse were bringing Resident #1 into the facility. She said LVN B assessed Resident #1 with no visual injuries noted. She said she called the Administrator, the DON, and his family. She said Resident #1 was in the dining room eating his supper around 5:30 p.m. which was the last time she had seen him. She said without the staff knowing Resident #1 had left the facility he could have been injured or hit by a car. She said Resident #1 had attempted to leave the facility before but nothing like this. She said they just redirected him mostly. She said she did not do an elopement assessment or update his care plan on his attempts to leave the facility because she was not aware she needed to do them. She said she believed she told the Administrator and DON of his prior attempts. During an interview on [DATE] at 5:50 p.m., LVN C said he received a call from the MDS nurse on [DATE], but he was unable to recall at what time the phone call was received. He said the MDS nurse reported Resident #1 was outside the facility between the facility and the shopping center. He said he went outside and when he saw Resident #1, he was in the shopping center parking lot. He said he and the MDS nurse brought Resident #1 back to the facility. He said he assessed him with no visual injuries. He said Resident #1 made the statement he was going to do it again (leave the facility). He said he then went to see how Resident #1 left the facility. He said it appeared he unscrewed the bolts with his hands on the door and then kicked the door open. He said the magnetic hardware was still attached to the door therefore the alarm did not go off. He said he found the screws and screwed them back in. He said the maintenance staff was called, and they returned to the facility and retightened the screws. He said the door had been properly repaired since Resident #1's elopement. During an interview on [DATE] at 12:34 p.m., LVN D said she had been employed at the facility for about 6 months. She said Resident #1 had some changes in his behavior since mid-February and had escalated since that time. She said Resident #1 pulled on the front door several times before he eloped on [DATE]. She said she was instructed by the ADON and DON to redirect Resident #1 when she saw him near the exit doors and she instructed the aides to do the same. She said she was not aware of any elopement assessments, or how to update a care plan. She said she was a new nurse, and this was her first job. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:34 p.m., CNA EE said she knew Resident #1. She said Resident #1 was quiet when he came to the facility but over the last few months, he changed. She said he was coming out of his room and saying he wanted to leave the facility and he attempted to leave a few times before he eloped on [DATE]. She said the nurses were aware and they monitored him mostly. She said she remembered one time they sent him to the hospital because he would not leave the front door but when he returned, he was still saying he was going to leave the facility. The nurses on duty were aware, but she was unable to recall their names. During an attempted phone interview on [DATE] at 3:00 p.m., with the previous ADON was unsuccessful, a message was left. During an attempted phone interview on [DATE] at 3:10 p.m., with the previous Administrator was unsuccessful, a message was left. During a phone interview on [DATE] at 3:44 p.m., the facility NP said she was seeing Resident #1. She said she was aware of his threats to leave the facility, and of his previous attempts to leave the facility. She said he told her before he would rather be homeless or go to prison than reside at the facility. She said he received psychiatric services, and they were adjusting his medications. During an interview on [DATE] at 1:33 p.m., the previous ADON said Resident #1 was aggressive and an elopement risk. She said Resident #1 attempted to leave the facility on several occasions before he eloped on [DATE]. She said she had consulted psychiatric services, and she instructed staff to stay with the resident or call the police if needed when he attempted to leave the facility. She said she could not recall them making referrals to other facilities even after he had made statements and/or attempts to leave the facility. She said after Resident #1 eloped they placed him on 1:1, and shortly afterward gave him a 30-day notice. She said they started making referrals to other facilities and notified the Ombudsman. She said she did not know the facility's elopement policy. During an attempted phone interview on [DATE] at 2:00 PM, Resident #1 was unable to be reached. During an interview on [DATE] at 5:00 p.m., the previous Administrator said she was the Administrator when Resident #1 eloped. She said she was notified the MDS nurse drove by the facility and saw Resident #1 going towards the shopping center away from the facility. She said after they brought Resident #1 into the facility, they placed him on 1:1. She said there were times when Resident #1 said he wanted to leave the facility before he eloped on [DATE]. She said during the times Resident #1 attempted to leave the facility or made statements he wanted to leave the facility; they did not have a social worker; so, she was doing the best she could. She said looking back they should have placed him on 1:1 after he started making statements or attempted to leave the facility. She said she could not recall the elopement policy for the facility. Record review of the facility's policy, Elopement Prevention , dated ,d+[DATE], reflected, Policy Statement Every effort will be made to prevent elopement episodes while maintaining the least restrictive environment for residents who are at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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, an interview with the resident/family, or a 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. 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 into the resident's care plan and medical record. Staff Training: Staff will receive training during their orientation process and then annually regarding: o Elopement prevention o Operation of all exit devices o Actions to take if elopement occurs effective transition of care. Record review of the facility's policy, Elopement Response, dated ,d+[DATE], reflected Policy Statement: 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. Policy Interpretation and Implementation: 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. 4. Should an employee discover the resident is missing from the facility (Code Orange), he/she should: A. Report to the charge nurse 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. 8e Documentation: An event note is to be made out on all residents who, without knowledge of the staff, leave the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Including the following: o Date o Time resident was first determined missing o Responsible party notified and time o Attending physician notified and time o Emergency Personnel o Condition of resident when located o Where located and time located Complete and file an incident report and o Make appropriate entries into the resident's medical record. o After an elopement the care plan coordinator will reevaluate the resident's care plan. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:51 p.m. The Administrator was notified. The Administer was provided with the IJ template on [DATE] at 6:05 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 2:30 p.m.: 1. As of 7 /,d+[DATE], Resident #1 no longer resides in the facility. 2. Elopement risk assessments for all residents in the facility were completed and reviewed by the DON/ADON/Designee on [DATE]. No additional concerns were identified. 3. All elopement risk care plan interventions were reviewed on [DATE] by the Regional Compliance Nurse, DON, and ADON. All interventions are in place and care planned. 4. The Administrator, DON, and ADON were in-serviced 1:1 by the Regional Compliance Nurse on [DATE] on the following: a. Elopement Prevention Policy to include implementing interventions for residents at risk. b. Elopement Response Policy 5. The Medical Director was notified of the immediate jeopardy on [DATE]. 6. An additional QAPI meeting was conducted on [DATE] to discuss the immediate jeopardy citation and subsequent plan of correction. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-services: 1. The Regional Compliance Nurse, Administrator, DON, and ADON will in-service all staff on the following topics below. All staff not present for the in-services will not be allowed to work their next shift until the in-service are completed. All new hires will be in-serviced during orientation prior to working their shift. All agency staff will be in-serviced prior to assuming their scheduled shift. a. All staff were in-serviced on the elopement response policy by the Compliance Nurse, Administrator and DON on [DATE]. b. All staff were in-serviced on elopement prevention by the Compliance Nurse, Administrator, and DON on [DATE]. Monitoring of the POR included the following: Observation of the 400 hall exit door revealed it was repaired. During Interviews on [DATE] from 9:26 a.m. until 2:30 p.m. with 1 RN 6 am-6 pm (RN L), 1 PRN RN (RN FF), 6 am-6 pm 4 LVN (LVN B, LVN D, LVN E, and LVN F), 3 PRN LVNs 6p-6a (LVN A, LVN Z, LVN CC), 3LVNs PRN (LVN X, LVN Y, and LVNAA), and 6 am-2 pm 4 CNAs (CNA G, CNA V, CNA H and CNA S), 2 pm-10 pm 1 CNA (CNA EE), 10 pm-6 am 2 CNAs (CNA R, CNA DD,) 6 am-10 pm 1 CNA (CNA BB), 3 PRN CNAs (CNA J CNA W and CNA I), Dietary staff 4 Cooks (Cook O, [NAME] N, [NAME] M, and [NAME] Q), housekeeping department 2 housekeepers (Housekeeper L, Housekeeper K), Therapy Department 2 therapist (T and P) and the ADON, MDS, BOM, HR, Dietary manager, Maintenance supervisor, Housekeeping Supervisor, and activity director all who indicated they received a written in-service regarding the process of elopement prevention and response. Staff was able to state what to do if a resident made statements or attempts to leave the facility and what to do if a resident eloped from the facility. During a phone interview on [DATE] at 1:30 p.m., the facility medical doctor said he was aware of the IJ received and attended a QAPI meeting via phone. During an interview on [DATE] at 2:36 p.m. the DON said when a resident starts making statements, such as I want to leave, we do not dismiss the statements. Staff should report any statements or attempts to leave the facility to their management. She said even if staff believed a resident was joking, they should take any statements or attempts to leave the facility seriously. Staff should do another elopement assessment, update the care plan, and be thorough on what interventions they put in place. Resident #1 had a traumatic brain injury also known as TBI (damage to the brain which could affect the way a person thinks or behaves) so she said she would have done an in-service with staff about his disease process. She said she would educate staff on making sure they kept their eye on him and placed him on every 30-minute check. She said as management, she would coordinate with psychiatric services, the doctor, and any other outside resources. She said then she would have made referrals to a more equipped facility. She said the Administrator and herself were responsible for the safety and well-being of all residents. (continued on next page)

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