STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675109	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arapaho Rehabilitation and Care Center	1111 Rockingham Dr Richardson, TX 75080

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review the facility failed to ensure that all alleged violations involving neglect, are reported immediately, but not later than 2 hours after the allegation is made, to HHSC for 1 (Resident #1) of 6residents reviewed for reporting. The facility's Abuse Coordinator failed to report to HHSC Resident #1's elopement incident that occurred on 08/27/2024. This failure could place residents at risk of continued neglect. Findings Included: Record Review of Resident #1's Face Sheet, dated 08/27/2024 revealed he was a [AGE] year-old male admitted to the facility 11/03/2019. Relevant diagnoses included dementia, major depressive disorder, generalized anxiety disorder, weakness, unsteadiness on feet, blindness in one eye, and macular degeneration (vision impairments.) Record review of Resident #1's Quarterly Minimum Data Set (MDS,) dated 06/21/2024 revealed he was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 08. He was wheelchair bound and required partial/moderate assistance with shower/bathing and personal hygiene. Resident #1 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #1 was assessed as having adequate vision. Resident #1 was documented as not having wandering behavior at this time. Resident #1's MDS was assessed has having no evidence of an acute changes in mental status from resident's baseline, and behavior was not present for disorganized thinking . unclear or illogical flow of ideas . Additionally, Resident #1 was scored as behavior not exhibited for physical behavioral symptoms directed toward others (. hitting .) and behavior not exhibited for any rejection of care. Record review of Resident #1's Comprehensive Care Plan, dated 06/21/2024, revealed he was a full code, was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, vision/hearing problems . and had impaired visual function related to blindness in right eye, macular degeneration . Resident #1 was non-adherent to treatment plan . refuses meals and [does not] allow staff to weigh him. He also had impaired cognitive function and impaired thought process r/t dementia. Further review revealed there was no evidence of aggressive behaviors, wandering, elopement, and/or exit seeking behavior was documented. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

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Arapaho Rehabilitation and Care Center	1111 Rockingham Dr Richardson, TX 75080

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress Note by LPN Y, dated 08/27/2024, revealed: Resident eloped from facility, found in parking lot in the front of the building. no s/s of distress noted, V/S are normal, noted resident stated, I was looking for my brother, and my wife. resident found by facility staff member (therapy dept) nursing and all staff to closely monitor, report passed on to on-coming am nurse to f/u with pcp to for recommendations to obtain UA, rule out UTI, and notify Rp of elopement. Interview of LPN Y was attempted via telephone 08/28/2024 at 09:05 AM was unsuccessful. In interview with facility SLP on 08/28/2024 at 8:59 AM, she stated on 08/27/2024 at approximately 6:00 AM, when she was walking down the hall where the Therapy Service door was located, she observed Resident #1 located outside of the facility ambulating beyond the curb towards the parking lot area. She stated she did not hear the door alarm. She stated she did not see Resident #1 exit the facility and was not certain how he got out of the facility. SLP stated when she went outside to see Resident #1, he was confused, was ambulating without his wheelchair, but appeared uninjured. Record review of facility's Incident Report for August 2024, dated 08/28/2024, revealed documentation that Resident #1 eloped 08/27/2024 at 5:30 AM. In interview and record review with the facility's DON on 08/28/2024 at 9:35 AM, she stated that Resident #1 had episodes of confusion related to the development of UTIs. She stated Resident #1 has never left the building. She stated her interpretation of the incident documentation from on 8/27/24 was that he was never on the other side of the door and did not consider this incident an elopement. In interview with facility's Administrator on 08/28/2024 at 2:20 PM, he stated he was not aware of any wandering, exit seeking, and/or elopement behavior from Resident #1, did not consider the incident on 08/27/2024 an elopement, and thus did not report or investigate the incident. He declined to comment further at this time. Record review of facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program rev. 04/2021 revealed Policy Statement . Residents have the right to be free from abuse, neglect . 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment . 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Rockingham Dr Richardson, TX 75080	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interview and record review the facility failed to ensure that all alleged violations involving neglect were investigated following reporting any alleged allegations to HHSC for 1 (Resident #1) of 6 residents reviewed for investigation. The facility's Abuse Coordinator failed to investigate to HHSC Resident #1's elopement incident that occurred on 08/27/2024. This failure could place residents at risk of abuse, neglect, and/or exploitation. Findings Included: Record Review of Resident #1's Face Sheet, dated 08/27/2024 revealed he was a [AGE] year-old male admitted to the facility 11/03/2019. Relevant diagnoses included dementia, major depressive disorder, generalized anxiety disorder, weakness, unsteadiness on feet, blindness in one eye, and macular degeneration (vision impairments.) Record review of Resident #1's Progress Note by LPN Y, dated 08/27/2024, revealed: Resident eloped from facility, found in parking lot in the front of the building. no s/s of distress noted, V/S are normal, noted resident stated, I was looking for my brother, and my wife. resident found by facility staff member (therapy dept) nursing and all staff to closely monitor, report passed on to on-coming am nurse to f/u with pcp to for recommendations to obtain UA, rule out UTI, and notify Rp of elopement. Interview of LPN Y was attempted via telephone 08/28/2024 at 09:05 AM was unsuccessful. In interview with facility SLP on 08/28/2024 at 8:59 AM, she stated on 08/27/2024 at approximately 6:00 AM, when she was walking down the hall where the Therapy Service door was located, she observed Resident #1 located outside of the facility ambulating beyond the curb towards the parking lot area. She stated she did not hear the door alarm. She stated she did not see Resident #1 exit the facility and was not certain how he got out of the facility. SLP stated when she went outside to see Resident #1, he was confused, was ambulating without his wheelchair, but appeared uninjured. Record review of facility's Incident Report for August 2024, dated 08/28/2024, revealed documentation that Resident #1 eloped 08/27/2024 at 5:30 AM. Record review of facility's Every 15 Minute Check Sheet provided by facility DON on 08/28/2024 at 12:21 PM revealed staff documentation for monitoring of Resident #1 every 15 minutes between 08/27/2024 and 08/28/2024. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview and record review with the facility's DON on 08/28/2024 at 9:35 AM, she stated that Resident #1 had episodes of confusion related to the development of UTIs. When asked about Resident #1's elopement, she stated that Resident #1 has never left the building. When asked about the progress note referenced from 08/27/2024, she stated that her interpretation of the incident documentation was that he was never on the other side of the door and did not consider this incident an elopement. In interview with facility's Administrator on 08/28/2024 at 2:20 PM, he stated he was not aware of any wandering, exit seeking, and/or elopement behavior from Resident #1, did not consider the incident on 08/27/2024 an elopement, and thus did not report or investigate the incident. He declined to comment further at this time. Record review of facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program rev. 04/2021 revealed Policy Statement . Residents have the right to be free from abuse, neglect . 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment . 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on interviews and record review, the facility failed to ensure each resident received an accurate assessment, reflective of the resident's status for one (Resident #1) of six residents reviewed for accuracy of assessments. The facility failed to ensure Resident #1's Quarterly MDS assessment dated [DATE] accurately reflected that Resident #1 visual impairments. This failure could place residents at risk for not receiving care and services to meet their needs, diminished function of health, and regressions in their overall health. Findings included: Record Review of Resident #1's Face Sheet, dated 08/27/2024 revealed he was a [AGE] year-old male admitted to the facility 11/03/2019. Relevant diagnoses included blindness in one eye, and macular degeneration (vision impairments.) Record review of Resident #1's Quarterly Minimum Data Set (MDS,) dated 06/21/2024 revealed he was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 08. Resident #1 was assessed as having adequate vision. Record review of Resident #1's Comprehensive Care Plan, dated 06/21/2024, revealed he was a full code, was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, vision/hearing problems . and had impaired visual function related to blindness in right eye, macular degeneration . In interview with the facility's MDS nurse on 08/28/2024 at 9:21 AM, she stated she began employment at the facility on 07/08/2024. She stated she did not complete his recent quarterly assessment dated [DATE]. She stated she has not had the chance to review past documentation when asked if she was knowledgeable of his clinical condition. She stated she had participated in multiple interdisciplinary meetings at the facility, but his vision had not been a topic of discussion. She stated if she was made aware of the inconsistency listed on his MDS, she would have updated Resident #1's MDS, and ensured adequate care interventions implemented on Resident #1's Comprehensive Care Plan. She stated it was her responsibility to ensure a resident's MDS was accurate to ensure a resident's care needs were accurately reflected and for the safety of the resident. In interview with facility's DON on 08/28/2024 at 9:35 AM, she stated she was aware that Resident #1 had vision deficits. She stated that Resident #1's MDS should accurately reflect his vision deficits; but prior to the current MDS nurse they had a MDS nurse working remotely and must have missed it. She stated ultimately it was a combined effort between nursing leadership and the facility's MDS nurse to ensure the accuracy of resident assessments and it was important for the MDS to accurately reflect resident care needs for the safety of the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy, Resident Assessments, rev. 03/2022 revealed A comprehensive assessment of every resident's needs is made at intervals . are federally mandated, and therefore must be performed for all residents of Medicare and/or Medicaid . provide information about the clinical condition . in order to be reimbursed . 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate assessments and reviews according to . Admission assessment . Quarterly assessment Annual assessment . Significant change in Status Assessment

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42824 Based on observation, interview and record review, the facility failed to ensure the comprehensive care plan described the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one (Residents #1) of four residents reviewed for Comprehensive Care Plans. The facility failed to devise and implement any Comprehensive Care Plan goals and/or interventions for Resident #1's documented wandering, exit seeking, and/or elopement behavior on 07/16/2024 to prevent an incident of elopement by Resident #1 on 08/27/2024. Additionally, Resident #1 had a documented history of physical aggression on 07/16/2024 at 9:20 PM that necessitated the relocation of his roommate but was not updated on his Comprehensive Care Plan. An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 08/28/2024 at 4:10 PM. While the POR was accepted on 08/29/2024 at 12:04 PM and the IJ lifted at 08/29/2024 at 3:45 PM, the facility remained out of compliance at a severity level of potential for minimum harm and scope of isolated/pattern, due to the facility's continued monitoring of the effectiveness of their plan of removal. This failure could place residents at risk of inappropriate, unsafe, and/or insufficient care based on insufficient Comprehensive Care Plans. Findings Included: Record Review of Resident #1's Face Sheet, dated 08/27/2024 revealed he was a [AGE] year-old male admitted to the facility 11/03/2019. Relevant diagnoses included dementia, major depressive disorder, generalized anxiety disorder, weakness, unsteadiness on feet, blindness in one eye, and macular degeneration (vision impairments.) Record review of Resident #1's Quarterly Minimum Data Set (MDS,) dated 06/21/2024 revealed he was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 08. He was wheelchair bound and required partial/moderate assistance with shower/bathing and personal hygiene. Resident #1 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #1 was assessed as having adequate vision. Resident #1 was documented as not having wandering behavior at this time. Resident #1's MDS was assessed has having no evidence of an acute changes in mental status from resident's baseline, and behavior was not present for disorganized thinking . unclear or illogical flow of ideas . Additionally, Resident #1 was scored as behavior not exhibited for physical behavioral symptoms directed toward others (. hitting .) and behavior not exhibited for any rejection of care. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Comprehensive Care Plan, dated 06/21/2024, revealed he was a full code, was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, vision/hearing problems . and had impaired visual function related to blindness in right eye, macular degeneration . Resident #1 was non-adherent to treatment plan . refuses meals and [does not] allow staff to weigh him. He also had impaired cognitive function and impaired thought process r/t dementia. Further review revealed there was no evidence of aggressive behaviors, wandering, elopement, and/or exit seeking behavior was documented. Record review of Resident #1's Comprehensive Care Plan history on 08/28/2024 at 10:15 Am revealed there were no revisions that referenced aggressive behaviors, wandering, elopement, and/or exit seeking behavior. Record review of Facility's Provider Investigation Report, authored by facility DON, dated 07/16/2024, revealed that facility staff observed [Resident #1] hitting his roommate . residents were separated immediately . and his roommate was relocated to another room . [Resident #1] had bruising noted to bilateral hands with no complaints of pain . and [Resident #1] was placed on frequent monitoring until evaluated by MD and/or psych . Record Review of Resident #1's Psychiatric Provider Visit Notes, dated 07/22/2024, revealed [Resident #1] recently had his roommate move out due to an altercation between them, he is unable to recall it but states he knows something happened . Staff reports he and previous roommate were in an altercation necessitating someone moving out . Upon examination, patient exhibited illogical thoughts . [Resident #1] obtained a score of 9 out of 15 on the BIMS score indicating moderate impairment . Record review of Resident #1's Progress Note authored by LVN X, dated 07/16/2024, revealed: Resident wheeled himself out of his room and pushed the 2100 hall door to outside and the door closed behind him and the CNA called this Nurse to open door for him, Resident stated that he wanted to get some fresh air. Notified ADON/DON of occurrence. Resident is back in his room safely. offered Resident snacks and fluids. call light within reach, bed in low position. Interview of LVN X was attempted via telephone 08/28/2024 at 11:18 AM and 08/29/2024 at 3:00 PM and was unsuccessful. Record review of Resident #1's Progress Note by LPN Y, dated 08/27/2024, revealed: Resident eloped from facility, found in parking lot in the front of the building. no s/s of distress noted, V/S are normal, noted resident stated, I was looking for my brother, and my wife. resident found by facility staff member (therapy dept) nursing and all staff to closely monitor, report passed on to on-coming am nurse to f/u with pcp to for recommendations to obtain UA, rule out UTI, and notify Rp of elopement. Interview of LPN Y was attempted via telephone 08/28/2024 at 09:05 AM was unsuccessful. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with facility SLP on 08/28/2024 at 8:59 AM, she stated on 08/27/2024 at approximately shift change at 6:00 AM, when she was walking down the hall where the Therapy Service door was located, she stated she observed Resident #1 located outside of the facility ambulating beyond the curb. She stated she did not hear the door alarm. She stated she did not see Resident #1 exit the facility and was not certain how he got out of the facility. SLP stated she was confident that Resident #1 did not know the door code, but that door was set to have an alarm go off if the code was not entered or when the door was left open for an extended amount of time. She stated she was not aware of any wandering or exit seeking behaviors from Resident #1 prior to this incident and was not aware of any previous elopement attempts. Record Review of facility's Incident Report for July 2024, dated 08/28/2024, revealed no documentation of Resident #1's wandering, exit seeking, and/or elopement behavior/incident from 07/16/2024. Record review of facility's Incident Report for August 2024, dated 08/28/2024, revealed documentation that Resident #1 eloped 08/27/2024 at 5:30 AM. Record review of facility's Every 15 Minute Check Sheet provided by the DON on 08/28/2024 at 12:21 PM revealed sufficient staff post-elopement monitoring documentation of Resident #1 every 15 minutes between 08/27/2024 and 08/28/2024. In interviews with Resident #1 on 08/27/2024 at 10:20 AM and 11:48 AM, revealed he did not recall any of the incidents, denied having any of aggressive behaviors, wandering, elopement, and/or exit seeking behaviors. Further interview was not successful due to the resident's cognitive status and confusion. In interview with Resident #1's nurse for the day, LVN C, on 08/27/2024 at 10:27 AM, she stated he was slightly confused and was not aware of any behaviors, accidents, or elopements. In interview with ADON A on 08/28/2024 at 9:07 AM, he stated he was aware of Resident #1's aggressive, wandering, elopement, and/or exit seeking behaviors. He stated was working on 07/16/2024 but was not certain of any follow-up re-assessments and/or interventions ADON A stated Resident #1's MDS and Comprehensive Care Plan should have been updated in response to these behaviors as it was significant change, that it was the MDS nurse's responsibility, stated it was important for resident MDS and Comprehensive Care Plans were updated as new resident behaviors were exhibited, to ultimately ensure accuracy and to reflect resident care needs. In interview with the facility's MDS nurse on 08/28/2024 at 9:21 AM, she stated she began employment at the facility on 07/08/2024 and was not aware of Resident #1's previous behaviors of aggression, wandering, elopement, and/or exit seeking; but stated she had not had the chance to review past documentation. She stated she had participated in multiple interdisciplinary meetings at the facility, but none of these behaviors were reported to her in any of these meetings. She stated if had been reported to her, she would have updated Resident #1's MDS, created and implemented care interventions on Resident #1's Comprehensive Care Plan for aggression, wandering, exit seeking, and/or elopement behaviors. She stated that after Resident #1's initial aggression, wandering and/or exit seeking behavior was exhibited, the facility should have re-assessed his risk level, implemented enhanced monitoring, and completed frequent documentation of where he was located. She stated these interventions were important to accurately reflect the care needs of the resident and for the safety of the resident. (continued on next page)

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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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview and record review with the facility's DON on 08/28/2024 at 9:35 AM, she stated that while the incident on 07/16/2024 was not an elopement, it was wandering, exit seeking, and/or elopement behavior and Resident #1 should have had an elopement reassessment, and the MDS and Comprehensive Care Plan should have been updated with interventions put in place. She also stated that she was not sure if his incident of aggression should have triggered revision of his Comprehensive Care Plan because again, she stated it was related to his development of a UTI. She stated it was the MDS nurse's responsibility to update these documents and to ensure interventions were implemented at the facility. The DON stated last month the facility had a remote MDS nurse and that was the reason the various assessments, revisions, and/or updates to resident documents were missed. She stated it was important for resident MDS and Comprehensive Care Plans to be updated when new behaviors were exhibited so the care was reflective of the resident needs. She stated it was ultimately her responsibility to ensure resident assessments, revisions, and/or any updates to resident documents were completed and accurate to best reflect resident care needs. Record review of facility policy Care Plans, Comprehensive Person-Centered rev. 03/2023 revealed, Policy Statement . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintained the residents highest practicable physical, mental, and psychosocial well-being . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 11. Assessments of residents are ongoing and care plans revised as information about the residents and the residents condition change. Record review of facility policy Resident-to-Resident Altercations, rev. 12/2016 revealed, .staff will: f. make any necessary changes in the care plan approaches to any or all of the involved individuals; g. document in the resident's clinical record all interventions and their effectiveness . Record review of facility policy, Wandering and Elopement Policy, rev. 03/2019 revealed, The facility will identify resident who are at risk of unsafe wandering and strive to prevent harm . 1. If identified as a risk for wandering, elopement . the resident's care plan will include strategies and interventions to maintain the resident's safety . 4. When the resident returns to the facility, the director of nursing services or charge nurse shall: 3. Document all events, interventions and outcomes in the resident record f. Review the event details during the QUAPI meeting to determine root cause and preventative measures. Record review of facility policy, Resident Assessments, rev. 03/2022 revealed A comprehensive assessment of every resident's needs is made at intervals . 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate assessments and reviews according to . Admission assessment . Quarterly assessment Annual assessment . Significant change in Status Assessment An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 08/28/2024 at 4:10 PM. While the POR was accepted on 08/29/2024 at 12:04 PM and the IJ lifted at 08/29/2024 at 3:45 PM, the facility remained out of compliance at a severity level of potential for minimum harm and scope of isolated, due to the facility's continued monitoring of the effectiveness of their plan of removal. (continued on next page)

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F 0656

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

The facility's Plan of Removal (POR) stated:

PLAN OF REMOVAL

Name of facility: [Facility]

Date: 08/28/2024

F 656

Immediate action:

The Medical Director was notified of the Immediate Jeopardy status on 08/28/2024 at 3:30pm.

Resident #1 continues to be a current resident at the facility. A head-to-toe assessment was completed on 08/27/2024 with no injuries or adverse effects noted. The resident was placed on Q15 checks on 08/27/2024 x 48 hours and will then be monitored hourly x 5 days. Psych Services saw the resident on 08/28/2024 and recommended that the resident be moved to a room closer to the nurse's station. Official report pending. The resident's elopement assessment was updated this evening and shows high risk. An off-cycle Significant Change MDS was opened with an ARD of 08/29/2024. The Care Plan was updated 08/28/2024 4:30 pm to reflect High Risk status with personalized interventions noted. If at any time the resident is determined to require a locked unit, the facility will seek placement elsewhere with the assistance of family and social services.

The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified. Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 6pm on 08/28/2024.

The following plan was implemented on 08/28/2024 to prevent residents from leaving the facility unsupervised.

PLAN TO IMPROVE THE FACILITY ELOPEMENT RESPONSE

1. Educate and Inservice staff on the:

Importance of accurate and timely elopement assessments

Accurate and timely MDS and care plan updates

Elopement Binder, contents, and location

Elopement definition including elopement behaviors

How to respond when a resident exhibits said behaviors

Notifications if an elopement occurs (Admin/ DON, MD, RP, HHSC reporting if criteria is met)

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER: Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1111 Rockingham Dr Richardson, TX 75080	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. An Elopement Drill is scheduled for 08/28/2024 for evening and night shift and 08/29/2024 for day shift to shift to ensure all staff know how to respond to elopements. 3. The Elopement Binder will be reviewed and updated accordingly once the Elopement Assessments have been completed. The Elopement Binder contents include the face sheet, resident pictures and Department Manager Contact Info). Elopement Binders are located at the reception desk and Nurses Station. The DON and/or designee will review the binder monthly to ensure that all new admissions and any Elopement Status changes have been captured. 4. The MDS and Care Plan will be updated with any significant change and/or quarterly or annual assessments depending on which assessment is required. The MDS Coordinator will ensure accuracy by reviewing the most recent Elopement Assessment. The DON will review the MDS prior to signing to ensure the information is accurate. MDS and Care Plan supporting documentation is located in the Resident's Electronic Medical Record. Facility Plan to Ensure Compliance Quickly Education was provided to the Administrator, and Director of Nurses by Divisional VP of Clinical Operations on the following items: Importance of accurate and timely elopement assessments Accurate and timely MDS and care plan updates Elopement Binder, contents (Face Sheet, Resident Pictures, Department Manager Contact Info), and location binder stored Elopement definition including elopement behaviors How to respond when a resident exhibits elopement behaviors (interventions) Notifications if an elopement occurs (Admin/ DON, MD, RP, HHSC reporting if criteria is met) Education will be provided to current staff by the Administrator and DON on the Elopement Management Process and policies, Elopement Binder and contents, Elopement definition including elopement behaviors and how to respond when a resident exhibit said behaviors and notifications if an elopement occurs. Nurse Management including DON, ADON, MDS Coordinator and Unit Managers will be educated on policies including the importance of accurate and timely elopement assessments with MDS and care plan updates by the [NAME] President of Clinical Reimbursement. The target date for training completion is Thursday, 08/29/2024 at 6 pm. New employees (all employees/ all disciplines) and agency nurses (if used) will be educated on the Elopement Management Process which includes the importance of accurate and timely elopement assessments with MDS and care plan updates; Elopement Binder and contents, Elopement definition including elopement behaviors and how to respond when a resident exhibits said behaviors and notifications if an elopement occurs. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A mass text went out to ALL employees regarding the required education/ in-servicing on the Elopement Management Process which must be received prior to returning to work for their next shift. Competency Testing must be completed and successfully passed before returning to work on their next shift. The DON and/ or designee will audit all new admissions and readmissions daily to ensure an elopement risk assessment has been completed and care planned with personalized interventions in place. The Administrator will audit new admissions in Morning Meeting with IDT to ensure the Elopement Assessment is completed, care planned and personalized. Elopement Risk Audits will be completed and reviewed by the Director of Nurses and/ or designee with each admission, readmission and change of condition. Quarterly assessments and reviews will remain ongoing to ensure that an appropriate and personalized plan of care is in place for residents at risk and to ensure that compliance and standards are met. Training on Elopement Management Process will be completed by Thursday 08/28/24 at 6 pm and will be provided to the staff by the Administrator and Director of Nurses and consist of the following action items: 1. If a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: 3. Attempt to prevent the resident from leaving in a non-threatening courteous manner 4. Request assistance from other staff member in the immediate vicinity as needed 5. Instruct another staff member to alert the charge nurse, Director of Nursing and/or Administrator of the resident's intent to leave the premises. 6. If a resident is missing, initiate the Elopement Management Process: 7. Determine if the resident is out on an unauthorized leave of absence. 8. If the resident was not authorized to leave, initiate a thorough search of the facility, grounds, and immediate areas surrounding the building. 9. If the resident is not located, notify the Administrator, the Director of Nursing, the Physician, the family/responsible party and law enforcement officials. 10. Follow HHSC's reporting guidelines. 11. When the resident returns to the facility, the director of nursing services or charge nurse shall: 12. Notify staff and examine the resident for injuries (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. Notify the physician and medical director of the resident return and assessment findings 14. Notify the family/ responsible party 15. Notify law enforcement 16. Document all events, interventions and outcomes in the resident record 17. Review the event details during the QAPI meeting to determine root cause and preventative measures. Re-education will be completed with the staff if any evidence of non-compliance is determined. The Director of Nurses will present audit findings to the QAPI committee each month until compliance achieved. Facility Monitoring Included: Record review of facility in-service training report, educational material, and sign in sheet for Administrator, DON, MDS, ADON A, ADON B, DOR, and Activity Director MDS/SIG Change/Timely Completion of Assessments dated 08/28/2024 conducted by [NAME] President of Clinical Reimbursement (VPCR) revealed Timely completion of Elopement Assessments (all assessments;) When a Significant Change in Status documentation and/or re-assessment is required, and Examples of Decline. In Interviews on 08/29/2024 between 11:16 AM and 2:52 PM with facility Administrator, DON, MDS, ADON A, ADON B, DOR, and Activity Director revealed sufficient understanding of in-services related to: Contents and importance of Care Plans, Timely completion of Elopement Assessments (all assessments;) When a Significant Change in Status documentation and/or re-assessment is required, and Examples of Decline. In Interviews on 08/29/2024 between 11:16 AM and 2:19 PM with LVN C, LVN D, LVN E, LVN F, LVN V, CNA G, CNA H, CNA I, CNA J, CNA K, CNA L, CMA M, Admission Coordinator, SLP N, SLP O, PT P, PT Q, OT R, OT S, COTA, PTA T, and PTA U revealed sufficient understanding of in-services related to: Contents and importance of Care Plans, Timely completion of Elopement Assessments (all assessments;) When a Significant Change in Status documentation and/or re-assessment is required, and Examples of Decline. Record Review on 08/29/2024 at 2:35 PM revealed Resident #1's MDS and Comprehensive Care Plan were updated to reflect resident's current behaviors and elopement risk. In observation of Resident #1 on 08/29/2024 at 2:45 PM he was in his room resting. An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 08/28/2024 at 4:10 PM. While the IJ was lifted at 08/29/2024 at 3:45 PM, the facility remained out of compliance at a severity level of potential for minimum harm and scope of isolated, due to the facility's continued monitoring of the effectiveness of their plan of removal.

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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** 42824 Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents and/or hazards for one (Resident #1) of four residents reviewed for elopement behavior. Resident #1 had a documented history of wandering and/or exit seeking behavior on 07/16/2024. The facility failed to provide adequate supervision to Resident #1 who had a history of exit seeking behavior. The facility did not accurately re-assess his elopment risk assessment, monitor, or update the residents care plan after the incident. On 08/27/2024 around approximately 6:00 AM the resident was located by the facility's SLP outside the facility beyond the Therapy Services door. An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 08/28/2024 at 4:10 PM. While the POR was accepted on 08/29/2024 at 12:04 PM and the IJ lifted at 08/29/2024 at 3:45 PM, the facility remained out of compliance at a severity level of potential for minimum harm and scope of isolated, due to the facility's continued monitoring of the effectiveness of their plan of removal. This failure could place residents at risk of becoming lost, disoriented, injured, and/or death from exposure to environmental elements. Findings Included: Record Review of Resident #1's Face Sheet, dated 08/27/2024 revealed he was a [AGE] year-old male admitted to the facility 11/03/2019. Relevant diagnoses included dementia, major depressive disorder, generalized anxiety disorder, weakness, unsteadiness on feet, blindness in one eye, and macular degeneration (vision impairments.) Record review of Resident #1's Quarterly Minimum Data Set (MDS,) dated 06/21/2024 revealed he was moderately cognitively impaired with a Brief Interview of Mental Status (BIMS) score of 08. He was wheelchair bound and required partial/moderate assistance with shower/bathing and personal hygiene. Resident #1 was occasionally incontinent of bladder and frequently incontinent of bowel. Resident #1 was assessed as having adequate vision. Resident #1 was documented as not having wandering behavior at this time. Record review of Resident #1's Comprehensive Care Plan, dated 06/21/2024, revealed he was a full code, was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, vision/hearing problems . and had impaired visual function related to blindness in right eye, macular degeneration . The care plan did not address the residents wandering, elopement, and/or exit seeking behavior. Record review of Resident #1's Progress Note by LPN Y, dated 08/27/2024, revealed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident eloped from facility, found in parking lot in the front of the building. no s/s of distress noted, V/S are normal, noted resident stated, I was looking for my brother, and my wife. resident found by facility staff member (therapy dept) nursing and all staff to closely monitor, report passed on to on-coming am nurse to f/u with pcp to for recommendations to obtain UA, rule out UTI, and notify Rp of elopement. Interview of LPN Y was attempted via telephone 08/28/2024 at 09:05 AM was unsuccessful. In interview with facility SLP on 08/28/2024 at 8:59 AM, she stated on 08/27/2024 at approximately shift change at 6:00 AM, when she was walking down the hall where the Therapy Service door was located, she stated she observed Resident #1 located outside of the facility ambulating beyond the curb. She stated she did not hear the door alarm. She stated she did not see Resident #1 exit the facility and was not certain how he got out of the facility. The SLP stated she was confident that Resident #1 did not know the door code. She stated that door was set to have an alarm go off if the code was not entered or when the door was left open for an extended amount of time. She stated she thought he perhaps followed a staff member out exiting the facility around shift change. The SLP stated when she went outside to see Resident #1, he was confused, and ambulating was without his wheelchair. She stated she then alerted nursing staff who came out to assess the resident. She stated she was not aware of any wandering or exit seeking behaviors from Resident #1 prior to this incident and was not aware of any previous elopement attempts. Record review of Resident #1's Progress Note authored by LVN X, dated 07/16/2024, revealed: Resident wheeled himself out of his room and pushed the 2100 hall door to outside and the door closed behind him and the CNA called this Nurse to open door for him, Resident stated that he wanted to get some fresh air. Notified ADON/DON of occurrence. Resident is back in his room safely. offered Resident snacks and fluids. call light within reach, bed in low position. An interview of LVN X was attempted via telephone 08/28/2024 at 11:18 AM and 08/29/2024 at 3:00 PM and was unsuccessful. An interview with facility's ADON on 08/28/2024 at 9:07 AM, he stated he was working on 07/16/2024. He recalled that the alarm was triggered by Resident #1 and we brought him back in. He stated the incident was not considered an elopement because the mechanisms in place worked. In interview with the facility's MDS nurse on 08/28/2024 at 9:21 AM, she stated she began employment at the facility on 07/08/2024 and was not aware of Resident #1's previous wandering behaviors prior to 08/27/2024. She stated she has not had the chance to review past documentation. She stated she had participated in multiple interdisciplinary meetings at the facility, but this specific incident was not reported to her in any of these meetings. She stated if had been reported to her, she would have updated Resident #1's MDS, created and implemented care interventions on Resident #1's Comprehensive Care Plan for wandering, exit seeking, and/or elopement behavior. She stated that after Resident #1's initial wandering and/or exit seeking behavior was exhibited, the facility should have re-assessed his risk level, implemented enhanced monitoring, and completed frequent documentation of where he was located. She stated these interventions were important to accurately reflect the care needs of the resident and for the safety of the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview and record review with the facility's DON on 08/28/2024 at 9:35 AM, she stated that Resident #1 has been at the facility quite a long time. She stated he was not one we were worried about eloping. She stated his episodes of confusion were related to the development of an UTI. She stated that her interpretation of the incident documented on 07/16/24the Progress Note was that he was never on the other side of the door. The DON stated after reviewing Resident #1's progress note from 07/16/2024, she did not consider this an elopement. She stated the resident has never left the building. She stated it was not an elopement, it was wandering, exit seeking, and/or elopement behavior and Resident #1 should have had an elopement reassessment, and the MDS and Care Plan should have been updated with interventions put in place. She stated it was the MDS nurse's responsibility to update these documents. The DON stated during this time the facility had a remote MDS nurse and that was the reason this was missed. She stated it was important for resident MDS and Comprehensive Care Plan to be updated when new behaviors were exhibited so the care was reflective of the resident needs. She stated she was aware of his confusion, did not think he was safe to be outside of the facility unsupervised, and it was ultimately her responsibility to ensure resident assessments and care plans were updated and accurate. Record review of Resident #1's Wandering/Elopement assessment dated [DATE] revealed he was scored as 1.0 - Low Risk for Wandering. Record review of Resident #1's All Inclusive Quarterly Screen dated 07/24/2024 revealed he was moderately impaired with limited vision and was a 2. Moderate Risk for elopement. Record Review of facility's Incident Report for July 2024, dated 08/28/2024, revealed no documentation of Resident #1's wandering, exit seeking, and/or elopement behavior/incident from 07/16/2024 Record review of facility's Incident Report for August 2024, dated 08/28/2024, revealed Resident #1 eloped 08/27/2024 at 5:30 AM. Record review of facility's Every 15 Minute Check Sheet provided by the DON on 08/28/2024 at 12:21 PM revealed sufficient staff documentation for monitoring of Resident #1 every 15 minutes 08/27/2024 and 08/28/2024. In interviews with Resident #1 on 08/27/2024 at 10:20 AM and 11:48 AM, he did not recall either incident, and a meaningful interview was not possible due to the resident's cognitive status and confusion. In interview with LVN C on 08/27/2024 at 10:27 AM, she stated Resident #1 was slightly confused and was not aware of any behaviors, accidents, or elopements. In interview with facility's Administrator on 08/28/2024 at 2:20 PM, he stated he was not aware of any wandering, exit seeking, and/or elopement behavior from Resident #1. He stated when he spoke with the facility's DON the morning of 08/27/2024, she reported to him that Resident #1 was seen outside of the building, but it was not considered an elopement. Upon further interview, Administrator declined to comment further at this time. (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 and Interview on 08/28/2024 at 1:00 PM with facility's DON, she provided a document that revealed Resident #1's Elopement Risk Assessments, dated 08/28/2024, that revealed his elopement risk was documented as Low Risk on 08/27/2024 and Moderate Risk on 08/28/2024. When asked how his risk could be low or moderate after an actual documented elopement, she stated she would get back with me on that. Record review on 08/28/2024 at 1:30 PM the facility's DON, provided a document that revealed Resident #1 Elopement Risk Assessment, dated 08/28/2024 at 1:00 PM, that revealed his elopement risk was documented now a High Risk. Supplementary comments on the document revealed Incident isolated. Resident has never attempted to leave the facility or open a door. Facility suspects UTI. Resident will be monitored closely until evaluated by MD. In Interview with facility's Administrator on 08/29/2024 at 2:52 PM he stated that he did not consider the incident on 08/27/2024 an elopement and declined to further comment. Record review of facility policy Care Plans, Comprehensive Person-Centered rev. 03/2023 revealed, Policy Statement . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintained the residents highest practicable physical, mental, and psychosocial well-being . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 11. Assessments of residents are ongoing and care plans revised as information about the residents and the residents condition change. Record review of facility policy Resident-to-Resident Altercations, rev. 12/2016 revealed, Policy Statement . All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the nursing supervisor, the director of nursing services and to the administrator . 2. If two residents are involved in an altercation, staff will: f. make any necessary changes in the care plan approaches to any or all of the involved individuals; g. document in the resident's clinical record all interventions and their effectiveness . Record review of facility policy, Wandering and Elopement Policy, rev. 03/2019 revealed, The facility will identify resident who are at risk of unsafe wandering and strive to prevent harm . 1. If identified as a risk for wandering, elopement . the resident's care plan will include strategies and interventions to maintain the resident's safety . 4. When the resident returns to the facility, the director of nursing services or charge nurse shall: 3. Document all events, interventions and outcomes in the resident record f. Review the event details during the QUAPI meeting to determine root cause and preventative measures. Record review of facility policy, Abuse, Neglect, Exploitation and Misappropriation Prevention Program rev. 04/2021 revealed Policy Statement . Residents have the right to be free from abuse, neglect . 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment . 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. (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 facility policy, Resident Assessments, rev. 03/2022 revealed A comprehensive assessment of every resident's needs is made at intervals . are federal mandated, and therefore must be performed for al residents of Medicare and/or Medicaid . provide information about the clinical condition . in order to be reimbursed . 1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate assessments and reviews according to . Admission assessment . Quarterly assessment Annual assessment . Significant change in Status Assessment An Immediate Jeopardy (IJ) situation was identified due to the above failures and presented to the Administrator on 08/28/2024 at 4:10 PM and an IJ template was provided.The POR was accepted on 08/29/2024 at 12:04 PM and indicated: The facility's Plan of Removal (POR) stated: PLAN OF REMOVAL Name of facility: [Facility] Date: 08/28/2024 F 689 Immediate action: The Medical Director was notified of the Immediate Jeopardy status on 08/28/2024 at 3:30pm. Resident #1 continues to be a current resident at the facility. A head-to-toe assessment was completed on 08/27/2024 with no injuries or adverse effects noted. The resident was placed on Q15 checks on 08/27/2024 x 48 hours and will then be monitored hourly x 5 days. Psych Services saw the resident on 08/28/2024 and recommended that the resident be moved to a room closer to the nurse's station. Official report pending. The resident's elopement assessment was updated this evening and shows high risk. An off-cycle Significant Change MDS was opened with an ARD of 08/29/2024. The Care Plan was updated 08/28/2024 4:30 pm to reflect High Risk status with personalized interventions noted. If at any time the resident is determined to require a locked unit, the facility will seek placement elsewhere with the assistance of family and social services. The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified. Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 6pm on 08/28/2024. The following plan was implemented on 08/28/2024 to prevent residents from leaving the facility unsupervised. PLAN TO IMPROVE THE FACILITY ELOPEMENT RESPONSE 1. Educate and Inservice staff on the: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Education will be provided to all current staff / all disciplines by the Administrator and DON on the Elopement Management Process and policies, Elopement Binder and contents, Elopement definition including elopement behaviors and how to respond when a resident exhibits said behaviors and notifications if an elopement occurs. Nurse Management including DON, ADON, MDS Coordinator and Unit Managers will be educated on policies including the importance of accurate and timely elopement assessments with MDS and care plan updates by the [NAME] President of Clinical Reimbursement The target date for training completion is Thursday, 08/29/2024 at 6 pm. New employees (all employees/ all disciplines) and agency nurses (if used) will be educated on the Elopement Management Process which includes the importance of accurate and timely elopement assessments with MDS and care plan updates; Elopement Binder and contents, Elopement definition including elopement behaviors and how to respond when a resident exhibits said behaviors and notifications if an elopement occurs. A mass text was sent to ALL employees regarding the required education/ in-servicing on the Elopement Management Process which must be received prior to returning to work for their next shift. Competency Testing must be completed and successfully passed before returning to work on their next shift. The DON and/ or designee will audit all new admissions and readmissions daily to ensure an elopement risk assessment has been completed and care planned with personalized interventions in place. The Administrator will audit new admissions in Morning Meeting with IDT to ensure the Elopement Assessment is completed, care planned and personalized. Elopement Risk Audits will be completed and reviewed by the Director of Nurses and/ or designee with each admission, readmission and change of condition. Quarterly assessments and reviews will remain ongoing to ensure that an appropriate and personalized plan of care is in place for residents at risk and to ensure that compliance and standards are met. Training on Elopement Management Process will be completed by Thursday 08/28/24 at 6 pm and will be provided to the staff by the Administrator and Director of Nurses and consist of the following action items: 1. If a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: 3. Attempt to prevent the resident from leaving in a non-threatening courteous manner 4. Request assistance from other staff member in the immediate vicinity as needed 5. Instruct another staff member to alert the charge nurse, Director of Nursing and/or Administrator of the resident's intent to leave the premises. 6. If a resident is missing, initiate the Elopement Management Process: 7. Determine if the resident is out on an unauthorized leave of absence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Arapaho Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Rockingham Dr Richardson, TX 75080	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. If the resident was not authorized to leave, initiate a thorough search of the facility, grounds, and immediate areas surrounding the building. 9. If the resident is not located, notify the Administrator, the Director of Nursing, the Physician, the family/responsible party and law enforcement officials. 10. Follow HHSC's reporting guidelines. 11. When the resident returns to the facility, the director of nursing services or charge nurse shall: 12. Notify staff and examine the resident for injuries 13. Notify the physician and medical director of the resident return and assessment findings 14. Notify the family/ responsible party 15. Notify law enforcement 16. Document all events, interventions and outcomes in the resident record 17. Review the event details during the QAPI meeting to determine root cause and preventative measures. Re-education will be completed with the staff if any evidence of non-compliance is determined. The Director of Nurses will present audit findings to the QAPI committee each month until compliance achieved. Facility Monitoring Included: Record review of facility in-service training report, educational material, comprehension quiz, and sign in sheet for Administrator and DON, Elopement Management Protocols, dated 08/28/2024 conducted by Divisional [NAME] President of Clinical Operations (DVP) revealed Contents or summary training . 1. Ensure elopement assessments are accurate and timely for all residents. 2. Accurate and timely MDS and Care Plan updates. 3. Elopement binder, contents, and location. 4. Elopement definition and behaviors. How to respond to elopement behaviors (interventions) and notifications should an elopement occur (Admin, DON, MD, RP, HHSC.) In Interviews on 08/29/2024 between 11:16 AM and 2:52 PM with facility Administrator and DON revealed sufficient understanding of in-services related to: Elopement Coordinator role and scope; any attempts to leave the facility MUST be reported to the Elopement Coordinator; risk factors for wandering, elopement, exit seeking; behavioral triggers for wandering, elopement, exit seeking; examples of behaviors of wandering, elopement, exit seeking; what to do if one notices these behaviors; location and contents of Elopement Risk Form and Elopement Binder; interventions for residents that are high risk for wandering, elopement, exit seeking; what to do if a resident is missing; and information and confirmation of elopement drills. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arapaho Rehabilitation and Care Center	1111 Rockingham Dr Richardson, TX 75080

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	Record review of facility in-service training report, educational material, and sign in sheet for all staff, Wandering and Elopement Policy/Elopement Drill, dated 08/28/2024 conducted by Administrator and DON revealed: Contents or summary of training . facilities Elopement Coordinator is Administrator . Any attempts to leave the facility MUST be reported to the Elopement Coordinator. This includes when a resident opens or attempts to open an outside door . Elopement definition and behaviors. How to respond to elopement behaviors and interventions. In Interviews on 08/29/2024 between 11:16 AM and 2:19 PM with ADON A, ADON B, LVN C, LVN D, LVN E, LVN F, LVN V, CNA G, CNA H, CNA I, CNA J, CNA K, CNA L, CMA M, MDS, Admission Coordinator, Activity Director, DOR, SLP N, SLP O, PT P, PT Q, OT R, OT S, COTA, PTA T, and PTA U revealed sufficient understanding of in-services related to: Elopement Coordinator role and scope; any attempts to leave the facility MUST be reported to the Elopement Coordinator; risk factors for wandering, elopement, exit seeking; behavioral triggers for wandering, elopement, exit seeking; examples of behaviors of wandering, elopement, exit seeking; what to do if one notices these behaviors; location and contents of Elopement Risk Form and Elopement Binder; interventions for residents that are high risk for wandering, elopement, exit seeking; what to do if a resident is missing; and information related to elopement drills. In Interviews on 08/29/2024 between 11:16 AM and 2:19 PM with ADON A, ADON B, LVN C, LVN D, LVN E, LVN F, LVN V, CNA G, CNA H, CNA I, CNA J, CNA K, CNA L, CMA M, MDS, Admission Coordinator, Activity Director, DOR, SLP N, SLP O, PT P, PT Q, OT R, OT S, COTA, PTA T, and PTA U revealed they had participated in the simulation of an elopement drill either 08/28/2024 or 08/29/2024 conducted by the Administrator or DON. Observation and record review on 08/29/2024 at 2:30 PM revealed located at the front desk and nurses station of and determined sufficient contents of the facility's Elopement Binder(s). In observation of Resident #1 on 08/29/2024 at 2:45 PM he was in his room resting. Review on 08/29/2024 at 2:35 PM revealed Resident #1's MDS and Comprehensive Care Plan updated by 08/29/2024 2:30 PM to reflect resident's current behaviors and elopement risk. An Immediate Jeopardy (IJ) was identified and presented to the Administrator on 08/28/2024 at 4:10 PM. While the POR was accepted on 08/29/2024 at 12:04 PM and the IJ lifted at 08/29/2024 at 3:45 PM, the facility remained out of compliance at a severity level of potential for minimum harm and scope of isolated, due to the facility's continued monitoring of the effectiveness of their plan of removal.