

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect for two of nine residents (Residents #1 and #2) reviewed for elopement.</p> <p>1. The facility failed to ensure Resident #1 did not elope from the facility. The facility failed to ensure Resident #1 was adequately supervised to prevent him from leaving the facility as 2-hour monitoring was not completed properly. Resident #1 had access to the door code for the front door although he had impaired cognitive function or thought processes related to Dementia and lacked safety awareness. Resident #1 eloped from the facility on 05/14/23 and was arrested the same day 3.5 miles away for impeding the progress of a southbound public train.</p> <p>2. The facility failed to ensure Resident #2 was supervised adequately and did not elope from the facility. Resident #2 was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. Resident #2 suffered a stroke and was hospitalized .</p> <p>An Immediate Jeopardy (IJ) was identified on 5/29/24 at 3:20 PM. The IJ template was provided to the facility on [DATE] 3:25 PM and signed by the Administrator. While the IJ was removed on 05/31/24 the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>These failures resulted in one arrest due to obstructing traffic and one hospitalization due to being found lying on the ground and had suffered a stroke.</p> <p>Findings included:</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675440
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>1. Review of Resident #1's quarterly MDS assessment, dated 05/02/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), epilepsy (abnormal electrical brain activity), muscle weakness, lack of coordination and anxiety (feeling of fear, dread, and uneasiness). The MDS reflected Resident #1 had a BIMS (Brief Interview for Mental Status - is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 10 indicating moderate cognitive impairment, moderately impaired decision-making, required cues/supervision. Under Section P - Restraints and Alarms revealed Resident #1 did not have any physical restraints (wander guard). Resident #1's undated Census Record reflected a discharge date of [DATE].</p> <p>Review of Resident #1's care plan revised on 05/08/24 revealed Resident #1 had an ADL self-care performance deficit related to activity intolerance, confusion, impaired balance was addressed. Interventions included encourage the resident to use the call light for assistance, he required extensive assistance x 1 staff for toileting and praise all efforts at self-care.</p> <p>Review of Resident #1's quarterly Elopement Risk Assessments, dated 02/12/24 and 05/12/24, revealed Resident #1 was ambulatory and had no history of wandering. The assessment reflected the Resident #1 was at a low risk for wandering with a score of 2.0 and had no reported episodes of wandering in the past 6 months.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 10:09 AM, written by LVN J revealed the resident is not in the building, his roommate said, he left at 1:30 AM and he has not come back.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 11:30 AM, written by SW revealed there were several groups of staff that went out looking for Resident #1 to find him. The groups returned unable to locate him.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 1:30 PM, written by SW revealed DPD notified the ADM that Resident #1 had been found in [. Jail]. SW called [. Jail] to find him and they were unable to locate him either in jail or in booking. SW then looked up Resident #1 in [. County Jail] and was able to find that Resident #1 had been picked up at 11:01 AM on 05/14/24 due to Obstruction of Highway Passageway.</p> <p>Review of the Provider Investigation Report dated 05/21/24 revealed Resident #1 was last seen on 05/13/24 at 8:30 PM in his room when taking his evening medications. On 05/14/24, CNA L served his breakfast tray at 08:30 AM and Resident #1 could not be found after searching inside the facility. DPD was notified on 05/14/24 of missing resident and was provided with a photo and face sheet. It further stated it was confirmed Resident #1 left the facility without anyone observing him, nor him notifying anyone and Resident #1 had been given the door code by another resident to go outside and smoke off property.</p> <p>Review of Resident #1's Smoking Safety Screen dated 02/01/24 and 05/01/24 revealed due to his diagnosis of dementia, Resident #1 was a supervised smoker.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of in-service training dated 05/14/24, after Resident #1's elopement, revealed training related to the procedure to follow when a resident was missing. The in-service did not address elopement prevention, ensuring wander-guard transmitters were routinely tested /checked to ensure they were functioning properly or training to ensure staff were able to demonstrate competency in monitoring and checking wander-guard transmitters.</p> <p>Review of DTP Police Report dated 05/14/24 revealed Resident #1 was arrested on Tuesday, 05/14/24 at approximately 08:30 AM . impeding the progress of a southbound [Company] train.</p> <p>Interview with a family member of Resident #1 on 05/23/24 at 9:45 AM, she stated the SW called her on 05/14/24 and informed her Resident #1 was missing. Resident #1's family member stated she had not spoken to, nor visited Resident #1 since November 2023. Resident #1's family member stated they have not found Resident #1, and the SW stopped communicating with her.</p> <p>Interview with the ADM on 05/23/24 at 10:30 AM, she stated due to Resident #1 not being exit-seeking, he did not wear a wander-guard transmitter. The ADM stated during their morning meeting on 5/14, it was reported by LVN J they were unable to locate Resident #1 inside the facility. The ADM stated LVN J informed her CNA L delivered Resident #1's breakfast tray to his room and then took residents out to smoke at 8:30 AM, but Resident #1 did not partake in neither. The ADM stated a report was filed with the DPD and a couple of hours later she was informed by DPD that Resident #1 was no longer considered missing as he had been arrested.</p> <p>Interview with the DON on 05/23/24 at 10:40 AM, she stated Resident #1 had not experienced a medical decline. The DON stated she believed Resident #1 had the door code because the only way you can get out without sounding the alarm, you would have to enter the door code. The DON stated Resident #1 had Dementia, but you would not know it by talking to him or looking at him.</p> <p>Interview with Resident #3 (Resident #1's roommate) on 05/23/24 at 12:00 PM, he stated Resident #1 did not tell him he was leaving. Resident #3 stated he woke up around 01:00 AM and Resident #1 was not in his bed. Resident #3 stated Resident #1 never mentioned he wanted to leave. Resident #3 stated all Resident #1 did was smoke and visit other residents. Resident #3 stated Resident #1 never showed any signs that he was leaving or that he did not like it here.</p> <p>Interview with Resident #4 (Resident #1's friend) on 05/23/24 at 12:20 PM, he stated Resident #1 would follow him outside and he may have seen him enter the door code to get out. Resident #4 denied intentionally providing the door code to Resident #1.</p> <p>Interview with DET A on 5/23/24 at 01:35 PM, he stated it was believed Resident #1 was arrested in [City] , but then it was determined he had been arrested by the DTP. DET A stated when he was assigned to locate Resident #1, he was not missing as he had already been arrested. DET A stated when he located Resident #1 in jail, his case was closed as Resident #1 was no longer considered a missing person.</p> <p>Interview with the MD on 5/23/24 at 01:50 PM, he stated he was made aware that Resident #1 eloped, and the police picked him up. The MD stated Resident #1 had never eloped before and did not exhibit any exit-seeking behaviors. The MD stated he had not been made aware that there were any concerns for Resident #1 smoking on his own. The MD stated Resident #1 had not had any change in conditions. The MD stated Resident #1 ambulated independently.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN H on 5/23/24 at 02:35 PM, she stated she worked on Monday, 5/13 from 2:00 PM until 10:00 PM. LVN H stated she administered Resident #1's medication before the regular smoke break at 8PM. LVN H stated she saw Resident #1 return to his room after he finished smoking. LVN H stated she never saw Resident #1 come out of his room before she ended her shift at 09:50 PM. LVN H stated Resident #1 was his normal self and had not had a change in condition. LVN H stated they are not supposed to give the door code to any residents. LVN H stated the door codes are now changed once a month. LVN H stated you must make sure the door was fully closed and locked and not allow any residents to exit behind you. LVN H stated the Residents that previously had the door code, had to be assessed by the SW. LVN H stated if a resident passed the Mental Mini-Assessment, they were allowed to sign themselves in and out. LVN H stated if you were unable to locate a resident, you must notify the ADM. LVN H stated then the ADM would instruct management to drive around the neighborhood and if they still could not find the resident, they would notify the police. LVN H stated if the resident was found, they would complete an assessment, an incident report and notify the doctor and the family. LVN H stated if the doctor gave an Order for a wander guard, they would place a wander guard on the resident. LVN H stated Resident #1 was not a wanderer.</p> <p>Interview with CNA K on 5/23/24 at 02:50 PM, he stated he saw Resident #1 the day prior on Monday (5/13). CNA K stated there were no concerns CNA K stated Resident #1 walked throughout the facility independently and went outside to smoke. CNA K stated the next morning on 5/14/24, he did not see Resident #1 up and walking around prior to taking his breakfast tray to his room. CNA K stated when he arrived at Resident #1's room around 07:50 AM, Resident #1 was not in his room. CNA K stated he told CNA L that Resident #1 was not in his room, and CNA L said to leave his breakfast tray because Resident #1 was probably outside smoking. CNA K stated he told LVN J that Resident #1 was not in his room, and LVN J said he may be smoking. CNA K stated around 9:00 AM, it was discovered Resident #1 had not come out to smoke, and they started searching for him inside and outside the facility. CNA K stated you were supposed to check on residents every 2 hours but now it was every 1 hour. CNA K stated when you complete the checks, you must chart in PCC any care provided. CNA K stated if you are just laying eyes on a Resident, you do not have to enter anything in PCC. CNA K stated you must now check residents off on the Rounding List only after physically laying eyes on them. CNA K stated he has never known for a resident to go missing. CNA K stated previously residents that were authorized to enter and exit with the door code, had the freedom to go as they please if they signed in and out. CNA K stated the door code was now changed once a month and only employees are allowed the code. CNA K stated whenever an employee enters or exits the facility, they must make sure the door was closed and locked so no resident follows them out.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 05/23/24 at 03:05 PM, the ADON stated Resident #1 was quiet and kept to himself. The ADON stated Resident #1 was usually alert and oriented. The ADON stated on Monday (5/13), Resident #1 tried to go out front to smoke by himself when the ADM was entering the building and she explained to Resident #1 that he must sign out first. The ADON stated Resident #1 complied and then went out and returned, and everything was fine. The ADON stated the next morning on 05/14/24, LVN J stated Resident #1 was not in his room or the common areas. The ADON stated the ADM had Management driving throughout the community searching for Resident #1. The ADON stated the ADM called DPD and Resident #1 was located in jail. The ADON stated Resident #1 had been arrested for obstructing traffic. The ADON stated each Resident must complete a Mini Mental Exam and depending on their score determines if they are allowed to sign themselves in and out, smoke unsupervised, or leave the facility without a family member. The ADON stated she does not know if anything could have been done differently because Resident #1 was not a wanderer, and he caught the facility off guard. The ADON stated they are making sure any resident that leaves the facility signs out and informs the nurse. The ADON stated the aides and nurses now completes rounds every hour. The ADON stated Resident #1 could have been hit by a vehicle, ended up in the hospital, or even killed.</p> <p>Interview with the ADM on 05/23/24 at 03:25 PM, she stated they have completed re-assessments on all residents to make sure the assessments were accurate. The ADM stated all residents that were already exit-seeking had a doctor's order to wear a wander guard. The ADM stated the SW had recently reassessed the residents that are allowed to sign themselves out. The ADM stated they completed in-services on 05/14/24 on rounding with each other and not by themselves. The ADM stated now nurses must print out the Midnight Census Report, give the report to the DON and text the ADM the headcount at midnight. The ADM stated they spoke with all the residents that are allowed to sign themselves out and informed them they must notify staff and make sure they sign in and out. The ADM stated they are having another in-service tomorrow on 05/24/24 on the same items.</p> <p>During an observation on 05/24/24 at 10:30 AM, Surveyor observed several Residents across from the entrance sitting in the dining area waiting to play bingo. The residents all denied being provided or knowing the door code to exit the facility.</p> <p>Interview with the SW on 05/24/24 at 11:00 AM, she stated Resident #1 did not have any change of conditions leading up to the elopement. The SW stated she drove throughout the neighborhood and could not locate Resident #1. The SW stated she looked Resident #1 up on the DPD website and confirmed that Resident #1 had been arrested for obstructing a highway passageway. The SW stated Resident #1 was not exit-seeking and did not wear a wander guard. The SW stated on 5/22/24 at 10:21 AM, Resident #1's daughter called her to get an update because she could not get through to the jail. The SW stated she looked Resident #1 up again on the DPD's website and it showed Resident #1 had been released the day prior on 5/21. The SW stated she drove downtown, around the jail and where the homeless people congregate and did not see Resident #1. The SW stated Resident #1's friend, Resident #4 most likely gave Resident #1 the door code. The SW stated Resident #4 was allowed to sign himself in and out and exit the facility using the door code. The SW stated Resident #1 was not allowed the door code due to his dementia diagnosis. The SW stated Resident #4 did not admit to giving Resident #1 the door code but suggested Resident #1 may have witnessed him entering it, or he may have given it to Resident #1 to enter.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN J on 05/24/24 at 01:20 PM, she stated she arrived to work late on 05/14/24. She stated while completing her rounds on 05/14/24 around 08:00 AM, she did not see anyone in Resident #1's room. LVN J stated this was around the time Resident #1 goes to smoke. LVN J stated after she completed her rounds, she went to receive the shift change report from the night nurse, LVN I. LVN J stated she went back to Resident #1's room to give him his medication, but he was not back. LVN J stated she checked the bathroom, and no one was in there. LVN J stated she went ahead and asked Resident #3 (roommate), and he responded, Resident #1 went out last night and he never came back. LVN J stated she asked CNA L if she had seen Resident #1 and she responded she had not seen him. LVN J stated she went to check his usual places, his friends' rooms and the smoking area and he was not there. LVN J stated she checked if Resident #1 signed himself out, but his name was not in the binder. LVN J stated she then requested all the CNAs to check every room, but Resident #1 could not be found. LVN J stated she then reported the information to the ADM. LVN J explained the old process for completing rounds was you would go to each room but did not have to sign anything. LVN J stated the new process has changed to hourly checks and if you arrive to a room and if the resident was not there you must look for them immediately. LVN J stated staff must now complete 15-minute door checks and someone would be stationed at the front desk 24-hours day. LVN J stated if someone were at risk for elopement you must complete an elopement assessment and the results would tell you if the resident was at risk. LVN J stated she would then inform the ADM, DON, and the ADON. LVN J explained the process for wander guards are each day on every shift, you must check to see if it was working. LVN J stated if the wander guard was not working properly, you must report it to the MD, the ADM, and the DON. LVN J stated if the wander guard were working properly, the light would be red, and it makes a continuous sound if a resident gets too close to the door. LVN J stated the alarm would have to be physically turned off at the nursing station. LVN J stated she was trained by the DON to take residents with wander guards to the front door to ensure the equipment was working properly. LVN J stated residents are not allowed to have the door code and staff must open the door for them to enter and exit the facility. LVN J stated she received a new door code, and the door code would now be changed monthly. LVN J stated Resident #1 could have been harmed, hit by a car, or even killed.</p> <p>Interview with CNA L on 05/24/24 at 01:40 PM, she stated when she arrived to work 05/14/24 at 6:00 AM, she completed her rounds noticed Resident #1 was not in his room and his bed was made. CNA L stated when the breakfast trays arrived on the floor at approximately 8:30 AM, and CNA K took Resident #1 his breakfast tray, he was still not in his room. CNA L stated LVN J asked her if Resident #1 was in his room when she completed her rounds and she stated, No. CNA L stated her, and CNA K searched the inside and outside of the facility and did not see Resident #1. CNA L stated the process for completing rounds did not have a checklist at the time. CNA L stated you would inform the nurse if there were any concerns. CNA L stated now there was a checklist. CNA L stated if a resident was not in their room, they must search all rooms and they cannot wait and assume the resident was smoking. CNA L stated now CNAs complete rounds every odd hour and Nurses complete rounds every even numbered hour. CNA L stated since the elopement, if any resident signs themselves out to smoke and if the resident was not back within 15 minutes, staff must check on them. CNA L stated she had two residents on her hall that wears a wander guard, and she must make sure the wander guard was working by observing the light taking the resident to the door to sound the alarm. CNA L stated she must then sign the wander guard binder at the front desk. CNA L stated there was a sign-out binder for residents to sign out and staff must walk the resident to the door. CNA L stated staff was not allowed to share the door code with anyone. CNA L stated she was unsure how the residents previously received access to the door code. CNA L stated prior to this incident, Resident #1 had never tried to elope.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Surveyor attempted to interview CNA M on 05/24/24 at 02:00 PM, Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record review of a Witness Statement dated 05/15/24 by CNA M revealed, I clocked in and walked his halls at 10:00 PM. Resident #1 was in his room. At approximately 11:00 PM, Resident #1 received ice. At midnight, Resident #1 was in his room. At 2:00 AM, another round was completed, and Resident #1 was in his room. During his last round at 4:00 AM, he assumed Resident #1 was asleep and did not disturb him nor his roommate.</p> <p>Surveyor attempted to interview LVN I on 05/24/24 at 02:15 PM. Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record review of a Witness Statement dated 05/15/24 sent in by LVN I revealed, I went to Resident #1's room early morning on 05/14/24 to administer medications to his roommate, Resident #3. I noticed Resident #1's bed was unmade, and Resident #3 was sitting in his wheelchair asleep in front of the television. There was light on in the restroom, the water was running, and the restroom door was closed all the way. I allowed Resident #1 to have privacy in the restroom. I left the main door unlocked per the roommate's request then moved on to the next room to continue passing medications.</p> <p>2. Review of Resident #2's admission MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive status was moderately impaired, and he had hallucinations. He did not have wandering behaviors. His diagnoses included heart failure, diabetes, and Non-Alzheimer's Dementia, hemiplegia, and multiple sclerosis.</p> <p>Review of Resident #2's Order Summary Report for May 2024 reflected:</p> <p>-04/24/24 Resident is wearing a wander guard device to the left ankle every shift for elopement.</p> <p>-04/24/24 To ensure that wander guard is functioning correctly, every shift take resident to front door to ensure that alarm sounds. If alarm does not sound, please alert Administrator as soon as possible every shift for elopement.</p> <p>Review of Resident #2's Care Plans reflected:</p> <p>-05/24/24 Resident is an elopement risk/wanderer related to dementia. Resident has a wander guard on his left ankle.</p> <p>Facility interventions included:</p> <p>Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.</p> <p>Identify pattern of wandering.</p> <p>Provide structured activities.</p> <p>Wander alert on left ankle. Monitor function and skin integrity every shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's Progress Notes reflected:</p> <p>-05/21/24 5:46 PM Resident noted packing his clothing and stating, I'm leaving I'm going home. Writer attempted to redirect resident. Unable to redirect resident. Writer called family; resident calmed down after speaking with family. - LVN A</p> <p>-05/22/24 2:30 PM Type: Behavior Note</p> <p>Resident insisted on leaving out the front door, despite receptionist attempts to redirect. Writer went outside and eventually was able to redirect resident to come back inside. Resident stated he wanted to go home. Called the wife and she said she was on the way. Resident appearing less agitated. - DON</p> <p>-05/22/24 5:09 PM SW spoke with resident about wanting to leave today. Resident was very agitated, upset, angry, and verbally making threats towards people. Resident verbalized that he was upset over his cigarettes and not seeing his family. SW took resident outside to smoke and talk. Resident became very agitated again and began to pace and not listen to redirection. Resident would partially deescalate and then allow himself to amp up once again. Resident Mrs. [NAME] is aware of his behaviors and actions. SW sent referral to two facilities. - SW</p> <p>-05/22/24 10:34 PM At approximately 7:27 PM alarm to the front door was sounding. Staff answered the alarm to discover resident was outside trying to leave the facility. Resident was stopped by staff and redirected back inside of facility. Resident placed on every 15-minute checks. - LVN A</p> <p>-05/23/24 9:15 AM Resident continues this morning to attempt leaving. Redirecting this behavior is getting more difficult. - DON</p> <p>-05/23/24 11:09 AM Late Entry Resident being sent to hospital for evaluation. Arranging transportation. - DON</p> <p>-05/23/24 12:12 PM Resident noted with his belongings packed at the front door mentioning that he was leaving and didn't want to stay in this F** place no more, called the wife who is also the POA to talk to his and encourage him to wait for the social worker to get him another home, resident got very agitated and angry, threatening to leave any way notified the NP who gave an order to send resident to hospital, notified the wife transport arrived to pick up resident he refused to leave without all his belongings, cigarettes, bible, urinal he carried everything with him into the van, wife on the phone trying to convince him not to go with belongings resident was very adamant. Resident transported to hospital, Dr notified and DON aware. - ADON</p> <p>-05/23/24 3:06 PM Resident returned from hospital at approximately 1:27 PM with no paperwork. Resident was alert, responsive, calm, and cooperative at that time. Resident ambulating with walker ab lib in hallways. Displays no distress. Denies any pain/discomfort. - LVN A</p> <p>-05/23/24 10:24 PM The resident had a psych consult today with NP. New orders received to discontinue risperidone (used to treat schizophrenia) 2 and 3 mg and start risperidone 5 mg at bedtime, Depakote DR (anti-seizure medication and treats bipolar disorder) 250mg twice daily, change venlafaxine (anti-depressant) to every morning and a Valproic acid level and CBC 7 days after starting Depakote. - LVN A</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>-05/25/24 3:01 PM Late Entry Resident forced himself out through the front door. Writer and another nurse ADON followed him and tried to redirect him, but resident did not want to listen or take directions. Resident was agitated and aggressive stating that he was going home. The ADON called resident's wife via video. Wife talked with the resident and asked him to come back into building. Wife told him that she will come to visit him today. Resident then came into the building. Resident redirected to his room. - LVN B</p> <p>-05/26/24 2:02 PM Resident followed another resident through the front door and forced himself outside. Writer tried to redirect resident and bring him back to the building, but resident refused and aggressively pushed the doors and got out. Writer then walked with the resident. Resident stated that he was going home, and he wanted to go buy cigarettes. Writer told resident that he had some cigarettes in the box. Resident then stated that he needed to sit down for few minutes. Writer stayed with resident outside for about 20 minutes. Resident then decided to come back into the building. Resident walked to his room and laid down on his bed. - LVN B</p> <p>-05/26/24 5:20 PM, Writer asked the other staff member if they had seen the resident. CNA on duty stated that they were outside in the smoke area with other residents, and he came back with other residents after the smoke break. Resident's walker noted at the dining hall, but resident is not there. Immediately all staff members alerted and started looking for the resident. All rooms searched but resident was not found. Administrator notified. Staff members went outside and searched around the building as some drove within the streets around, but resident was not found. Police notified and wife also called and notified. Staff members extended to search for the resident within the neighborhood, but resident was not found. Police arrived and were given description of the resident and gave the claim number. Police stated that if we find him before they do, we call them. - LVN B</p> <p>Review of Resident #2's Ambulance Record, dated 05/26/24, reflected:</p> <p>Dispatch notified: 7:31 PM</p> <p>On scene: 7:36 PM</p> <p>Resident transferred: 8:10 PM</p> <p>Patient was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. EMS arrived and transfer station staff were pouring water on him in an attempt to cool him off. EMS transported patient to the hospital.</p> <p>Review of Resident #2's Hospital Records, dated 05/26/24 8:30 PM, reflected:</p> <p>Chief Complaint: slurred speech, extremity weakness, fall, unable to respond to questioning. Temperature 98.9 degrees Fahrenheit.</p> <p>Final Diagnosis: Stroke</p> <p>Review of website: timeanddate.com on 05/29/24 reflected the following temperatures:</p> <p>[NAME] TX temperature:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 97 degrees</p> <p>Dallas TX temperature:</p> <p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 98 degrees</p> <p>Observation of Resident #2 on 05/25/25 at 1:20 PM, revealed the resident was wearing a wander-guard transmitter on the left lower extremity and the presence of the LED light indicated it was functional.</p> <p>Observation of Resident #2 on 05/25/24 at 03:15 PM, revealed the DM sitting one-on-one with Resident #2 in the facility's lobby with his wander-guard transmitter still visible on the left lower extremity and the presence of the LED light indicated it was functional.</p> <p>An interview on 05/25/24 at 01:00 PM, with the MTD he stated he adjusted the front door to make the door close faster and changed the door code. The MTD stated the front door was monitored by the wander-guard system. The MTD stated normally, [Company] instructed him over the phone how to change the door code, but this time, he had [Company] come to the facility and [Company] installed a button under the receptionist's desk in order to open the door remotely and provided him a manual on how to change the door code himself. The MTD stated there had not been any concerns and everything was working properly. The MTD stated he monitored the doors as needed to ensure they are closing properly. The MTD stated he completed door checks three times a day and completed Tail Logs for documentation purposes. The MTD stated he had never been aware of any residents being in possession of the door code.</p> <p>On 05/25/24 at 01:20 PM, Surveyor observed the five residents identified for placement of a Wander Guard. Surveyor observed the five residents in their rooms with their Wander Guard placed according to their individual Care Plans and Orders. Surveyor also conducted testing with the ADON at the front door to ensure the Wander Guards were functioning properly.</p> <p>An interview on 05/25/24 at 02:15 PM, with the DM, he stated he drove around looking for Resident #1 when he was reported missing. The DM stated he was in-serviced on not giving the door code out or allowing residents to follow anyone outside. The DM stated the door codes were changed and a remote access button was installed under the receptionist's desk.</p> <p>An interview on 05/25/24 at 02:30 PM, with HR, she stated she was in-serviced on making sure all residents know they must be buzzed in and out. HR stated no residents nor visitors should have access to the door code. HR stated the approved residents must sign in and out of the facility and let staff know they are leaving. HR stated the MTD changed the door codes last on Thursday, 05/23/24. HR stated when she ends her shift at 5:00 PM and over the weekend, various staff members would cover the front door.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 05/25/24 at 02:45 PM, HK O stated she was in-serviced on being more concerned when entering and exiting the front door. HK O stated she was informed the door code would be changed once a month. HK O stated she was informed to keep an eye on the residents that wear a Wander Guard.</p> <p>Interviews were conducted with facility staff across multiple shifts on 05/23/24, 05/24/24, and 05/25/24. Staff interviewed were LVN H, LVN J, CNA L, CNA K, CNA F, CNA G, CNA C, HK O, LVN B, LVN J and MA A.</p> <p>Interviews with the staff revealed they verbalized comprehension of the in-service training. They stated they had been in-serviced on obtaining orders when a resident was assessed and determined to require a wander guard to ensure the wander guard monitoring populated into the TARS. They stated they had been in-serviced on checking to ensure the wander guard was functional every shift by observing that the light was visible and taking residents to the front door to ensure the alarm sounded. Staff verbalized the wander guard could[TRUNCATED]</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37028</p> <p>Based on observations, interviews, and record reviews, the facility failed to implement written policies and procedures that prohibited and prevented abuse and neglect for two of nine residents (Resident #1 and Resident#2) reviewed for elopement.</p> <p>1. The facility failed to follow the policy and procedure for neglect which allowed Resident #1 to elope from the facility. The facility failed to ensure Resident #1 was adequately supervised to prevent him from leaving the facility as 2-hour monitoring was not completed properly. Resident #1 had access to the door code for the front door although he had impaired cognitive function or thought processes related to Dementia and lacked safety awareness. Resident #1 eloped from the facility on 05/14/23 and was arrested the same day 3.5 miles away for impeding the progress of a southbound public train.</p> <p>2. The facility failed to follow the policy and procedure for neglect which allowed Resident #2 to elope from the facility. The facility failed to ensure Resident #2 was supervised adequately and did not elope from the facility. Resident #2 was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. Resident #2 suffered a stroke and was hospitalized .</p> <p>An Immediate Jeopardy (IJ) was identified on 5/29/24 at 3:20 PM. The IJ template was provided to the facility on [DATE] 3:25 PM and signed by the Administrator. While the IJ was removed on 05/31/24 the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>These failures resulted in the failure to follow the policy for neglect as well as hospitalization with stroke.</p> <p>Findings included:</p> <p>Review of facility's policy Abuse and Neglect Clinical Protocol, revised March 2018, reflected:</p> <p>Neglect .the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>1. Review of Resident #1's quarterly MDS assessment, dated 05/02/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), epilepsy (abnormal electrical brain activity), muscle weakness, lack of coordination and anxiety (feeling of fear, dread, and uneasiness). The MDS reflected Resident #1 had a BIMS (Brief Interview for Mental Status - is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 10 indicating moderate cognitive impairment, moderately impaired decision-making, required cues/supervision. Under Section P - Restraints and Alarms revealed Resident #1 did not have any physical restraints (wander guard). Resident #1's undated Census Record reflected a discharge date of [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's care plan revised on 05/08/24 revealed Resident #1 had an ADL self-care performance deficit related to activity intolerance, confusion, impaired balance was addressed. Interventions included encourage the resident to use the call light for assistance, he required extensive assistance x 1 staff for toileting and praise all efforts at self-care.</p> <p>Review of Resident #1's quarterly Elopement Risk Assessments, dated 02/12/24 and 05/12/24, revealed Resident #1 was ambulatory and had no history of wandering. The assessment reflected the Resident #1 was at a low risk for wandering with a score of 2.0 and had no reported episodes of wandering in the past 6 months.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 10:09 AM, written by LVN J revealed the resident is not in the building, his roommate said, he left at 1:30 AM and he has not come back.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 11:30 AM, written by SW revealed there were several groups of staff that went out looking for Resident #1 to find him. The groups returned unable to locate him.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 1:30 PM, written by SW revealed DPD notified the ADM that Resident #1 had been found in [. Jail]. SW called [. Jail] to find him and they were unable to locate him either in jail or in booking. SW then looked up Resident #1 in [. County Jail] and was able to find that Resident #1 had been picked up at 11:01 AM on 05/14/24 due to Obstruction of Highway Passageway.</p> <p>Review of the Provider Investigation Report dated 05/21/24 revealed Resident #1 was last seen on 05/13/24 at 8:30 PM in his room when taking his evening medications. On 05/14/24, CNA L served his breakfast tray at 08:30 AM and Resident #1 could not be found after searching inside the facility. DPD was notified on 05/14/24 of missing resident and was provided with a photo and face sheet. It further stated it was confirmed Resident #1 left the facility without anyone observing him, nor him notifying anyone and Resident #1 had been given the door code by another resident to go outside and smoke off property.</p> <p>Review of Resident #1's Smoking Safety Screen dated 02/01/24 and 05/01/24 revealed due to his diagnosis of dementia, Resident #1 was a supervised smoker.</p> <p>Review of in-service training dated 05/14/24, after Resident #1's elopement, revealed training related to the procedure to follow when a resident was missing. The in-service did not address elopement prevention, ensuring wander-guard transmitters were routinely tested /checked to ensure they were functioning properly or training to ensure staff were able to demonstrate competency in monitoring and checking wander-guard transmitters.</p> <p>Review of DTP Police Report dated 05/14/24 revealed Resident #1 was arrested on Tuesday, 05/14/24 at approximately 08:30 AM . impeding the progress of a southbound [Company] train.</p> <p>Interview with a family member of Resident #1 on 05/23/24 at 9:45 AM, she stated the SW called her on 05/14/24 and informed her Resident #1 was missing. Resident #1's family member stated she had not spoken to, nor visited Resident #1 since November 2023. Resident #1's family member stated they have not found Resident #1, and the SW stopped communicating with her.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the ADM on 05/23/24 at 10:30 AM, she stated due to Resident #1 not being exit-seeking, he did not wear a wander-guard transmitter. The ADM stated during their morning meeting on 5/14, it was reported by LVN J they were unable to locate Resident #1 inside the facility. The ADM stated LVN J informed her CNA L delivered Resident #1's breakfast tray to his room and then took residents out to smoke at 8:30 AM, but Resident #1 did not partake in neither. The ADM stated a report was filed with the DPD and a couple of hours later she was informed by DPD that Resident #1 was no longer considered missing as he had been arrested.</p> <p>Interview with the DON on 05/23/24 at 10:40 AM, she stated Resident #1 had not experienced a medical decline. The DON stated she believed Resident #1 had the door code because the only way you can get out without sounding the alarm, you would have to enter the door code. The DON stated Resident #1 had Dementia, but you would not know it by talking to him or looking at him.</p> <p>Interview with Resident #3 (Resident #1's roommate) on 05/23/24 at 12:00 PM, he stated Resident #1 did not tell him he was leaving. Resident #3 stated he woke up around 01:00 AM and Resident #1 was not in his bed. Resident #3 stated Resident #1 never mentioned he wanted to leave. Resident #3 stated all Resident #1 did was smoke and visit other residents. Resident #3 stated Resident #1 never showed any signs that he was leaving or that he did not like it here.</p> <p>Interview with Resident #4 (Resident #1's friend) on 05/23/24 at 12:20 PM, he stated Resident #1 would follow him outside and he may have seen him enter the door code to get out. Resident #4 denied intentionally providing the door code to Resident #1.</p> <p>Interview with DET A on 5/23/24 at 01:35 PM, he stated it was believed Resident #1 was arrested in [City] , but then it was determined he had been arrested by the DTP. DET A stated when he was assigned to locate Resident #1, he was not missing as he had already been arrested. DET A stated when he located Resident #1 in jail, his case was closed as Resident #1 was no longer considered a missing person.</p> <p>Interview with the MD on 5/23/24 at 01:50 PM, he stated he was made aware that Resident #1 eloped, and the police picked him up. The MD stated Resident #1 had never eloped before and did not exhibit any exit-seeking behaviors. The MD stated he had not been made aware that there were any concerns for Resident #1 smoking on his own. The MD stated Resident #1 had not had any change in conditions. The MD stated Resident #1 ambulated independently.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN H on 5/23/24 at 02:35 PM, she stated she worked on Monday, 5/13 from 2:00 PM until 10:00 PM. LVN H stated she administered Resident #1's medication before the regular smoke break at 8PM. LVN H stated she saw Resident #1 return to his room after he finished smoking. LVN H stated she never saw Resident #1 come out of his room before she ended her shift at 09:50 PM. LVN H stated Resident #1 was his normal self and had not had a change in condition. LVN H stated they are not supposed to give the door code to any residents. LVN H stated the door codes are now changed once a month. LVN H stated you must make sure the door was fully closed and locked and not allow any residents to exit behind you. LVN H stated the Residents that previously had the door code, had to be assessed by the SW. LVN H stated if a resident passed the Mental Mini-Assessment, they were allowed to sign themselves in and out. LVN H stated if you were unable to locate a resident, you must notify the ADM. LVN H stated then the ADM would instruct management to drive around the neighborhood and if they still could not find the resident, they would notify the police. LVN H stated if the resident was found, they would complete an assessment, an incident report and notify the doctor and the family. LVN H stated if the doctor gave an Order for a wander guard, they would place a wander guard on the resident. LVN H stated Resident #1 was not a wanderer.</p> <p>Interview with CNA K on 5/23/24 at 02:50 PM, he stated he saw Resident #1 the day prior on Monday (5/13). CNA K stated there were no concerns CNA K stated Resident #1 walked throughout the facility independently and went outside to smoke. CNA K stated the next morning on 5/14/24, he did not see Resident #1 up and walking around prior to taking his breakfast tray to his room. CNA K stated when he arrived at Resident #1's room around 07:50 AM, Resident #1 was not in his room. CNA K stated he told CNA L that Resident #1 was not in his room, and CNA L said to leave his breakfast tray because Resident #1 was probably outside smoking. CNA K stated he told LVN J that Resident #1 was not in his room, and LVN J said he may be smoking. CNA K stated around 9:00 AM, it was discovered Resident #1 had not come out to smoke, and they started searching for him inside and outside the facility. CNA K stated you were supposed to check on residents every 2 hours but now it was every 1 hour. CNA K stated when you complete the checks, you must chart in PCC any care provided. CNA K stated if you are just laying eyes on a Resident, you do not have to enter anything in PCC. CNA K stated you must now check residents off on the Rounding List only after physically laying eyes on them. CNA K stated he has never known for a resident to go missing. CNA K stated previously residents that were authorized to enter and exit with the door code, had the freedom to go as they please if they signed in and out. CNA K stated the door code was now changed once a month and only employees are allowed the code. CNA K stated whenever an employee enters or exits the facility, they must make sure the door was closed and locked so no resident follows them out.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview on 05/23/24 at 03:05 PM, the ADON stated Resident #1 was quiet and kept to himself. The ADON stated Resident #1 was usually alert and oriented. The ADON stated on Monday (5/13), Resident #1 tried to go out front to smoke by himself when the ADM was entering the building and she explained to Resident #1 that he must sign out first. The ADON stated Resident #1 complied and then went out and returned, and everything was fine. The ADON stated the next morning on 05/14/24, LVN J stated Resident #1 was not in his room or the common areas. The ADON stated the ADM had Management driving throughout the community searching for Resident #1. The ADON stated the ADM called DPD and Resident #1 was located in jail. The ADON stated Resident #1 had been arrested for obstructing traffic. The ADON stated each Resident must complete a Mini Mental Exam and depending on their score determines if they are allowed to sign themselves in and out, smoke unsupervised, or leave the facility without a family member. The ADON stated she does not know if anything could have been done differently because Resident #1 was not a wanderer, and he caught the facility off guard. The ADON stated they are making sure any resident that leaves the facility signs out and informs the nurse. The ADON stated the aides and nurses now completes rounds every hour. The ADON stated Resident #1 could have been hit by a vehicle, ended up in the hospital, or even killed.</p> <p>Interview with the ADM on 05/23/24 at 03:25 PM, she stated they have completed re-assessments on all residents to make sure the assessments were accurate. The ADM stated all residents that were already exit-seeking had a doctor's order to wear a wander guard. The ADM stated the SW had recently reassessed the residents that are allowed to sign themselves out. The ADM stated they completed in-services on 05/14/24 on rounding with each other and not by themselves. The ADM stated now nurses must print out the Midnight Census Report, give the report to the DON and text the ADM the headcount at midnight. The ADM stated they spoke with all the residents that are allowed to sign themselves out and informed them they must notify staff and make sure they sign in and out. The ADM stated they are having another in-service tomorrow on 05/24/24 on the same items.</p> <p>During an observation on 05/24/24 at 10:30 AM, Surveyor observed several Residents across from the entrance sitting in the dining area waiting to play bingo. The residents all denied being provided or knowing the door code to exit the facility.</p> <p>Interview with the SW on 05/24/24 at 11:00 AM, she stated Resident #1 did not have any change of conditions leading up to the elopement. The SW stated she drove throughout the neighborhood and could not locate Resident #1. The SW stated she looked Resident #1 up on the DPD website and confirmed that Resident #1 had been arrested for obstructing a highway passageway. The SW stated Resident #1 was not exit-seeking and did not wear a wander guard. The SW stated on 5/22/24 at 10:21 AM, Resident #1's daughter called her to get an update because she could not get through to the jail. The SW stated she looked Resident #1 up again on the DPD's website and it showed Resident #1 had been released the day prior on 5/21. The SW stated she drove downtown, around the jail and where the homeless people congregate and did not see Resident #1. The SW stated Resident #1's friend, Resident #4 most likely gave Resident #1 the door code. The SW stated Resident #4 was allowed to sign himself in and out and exit the facility using the door code. The SW stated Resident #1 was not allowed the door code due to his dementia diagnosis. The SW stated Resident #4 did not admit to giving Resident #1 the door code but suggested Resident #1 may have witnessed him entering it, or he may have given it to Resident #1 to enter.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with LVN J on 05/24/24 at 01:20 PM, she stated she arrived to work late on 05/14/24. She stated while completing her rounds on 05/14/24 around 08:00 AM, she did not see anyone in Resident #1's room. LVN J stated this was around the time Resident #1 goes to smoke. LVN J stated after she completed her rounds, she went to receive the shift change report from the night nurse, LVN I. LVN J stated she went back to Resident #1's room to give him his medication, but he was not back. LVN J stated she checked the bathroom, and no one was in there. LVN J stated she went ahead and asked Resident #3 (roommate), and he responded, Resident #1 went out last night and he never came back. LVN J stated she asked CNA L if she had seen Resident #1 and she responded she had not seen him. LVN J stated she went to check his usual places, his friends' rooms and the smoking area and he was not there. LVN J stated she checked if Resident #1 signed himself out, but his name was not in the binder. LVN J stated she then requested all the CNAs to check every room, but Resident #1 could not be found. LVN J stated she then reported the information to the ADM. LVN J explained the old process for completing rounds was you would go to each room but did not have to sign anything. LVN J stated the new process has changed to hourly checks and if you arrive to a room and if the resident was not there you must look for them immediately. LVN J stated staff must now complete 15-minute door checks and someone would be stationed at the front desk 24-hours day. LVN J stated if someone were at risk for elopement you must complete an elopement assessment and the results would tell you if the resident was at risk. LVN J stated she would then inform the ADM, DON, and the ADON. LVN J explained the process for wander guards are each day on every shift, you must check to see if it was working. LVN J stated if the wander guard was not working properly, you must report it to the MD, the ADM, and the DON. LVN J stated if the wander guard were working properly, the light would be red, and it makes a continuous sound if a resident gets too close to the door. LVN J stated the alarm would have to be physically turned off at the nursing station. LVN J stated she was trained by the DON to take residents with wander guards to the front door to ensure the equipment was working properly. LVN J stated residents are not allowed to have the door code and staff must open the door for them to enter and exit the facility. LVN J stated she received a new door code, and the door code would now be changed monthly. LVN J stated Resident #1 could have been harmed, hit by a car, or even killed.</p> <p>Interview with CNA L on 05/24/24 at 01:40 PM, she stated when she arrived to work 05/14/24 at 6:00 AM, she completed her rounds noticed Resident #1 was not in his room and his bed was made. CNA L stated when the breakfast trays arrived on the floor at approximately 8:30 AM, and CNA K took Resident #1 his breakfast tray, he was still not in his room. CNA L stated LVN J asked her if Resident #1 was in his room when she completed her rounds and she stated, No. CNA L stated her, and CNA K searched the inside and outside of the facility and did not see Resident #1. CNA L stated the process for completing rounds did not have a checklist at the time. CNA L stated you would inform the nurse if there were any concerns. CNA L stated now there was a checklist. CNA L stated if a resident was not in their room, they must search all rooms and they cannot wait and assume the resident was smoking. CNA L stated now CNAs complete rounds every odd hour and Nurses complete rounds every even numbered hour. CNA L stated since the elopement, if any resident signs themselves out to smoke and if the resident was not back within 15 minutes, staff must check on them. CNA L stated she had two residents on her hall that wears a wander guard, and she must make sure the wander guard was working by observing the light taking the resident to the door to sound the alarm. CNA L stated she must then sign the wander guard binder at the front desk. CNA L stated there was a sign-out binder for residents to sign out and staff must walk the resident to the door. CNA L stated staff was not allowed to share the door code with anyone. CNA L stated she was unsure how the residents previously received access to the door code. CNA L stated prior to this incident, Resident #1 had never tried to elope.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Surveyor attempted to interview CNA M on 05/24/24 at 02:00 PM, Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record review of a Witness Statement dated 05/15/24 by CNA M revealed, I clocked in and walked his halls at 10:00 PM. Resident #1 was in his room. At approximately 11:00 PM, Resident #1 received ice. At midnight, Resident #1 was in his room. At 2:00 AM, another round was completed, and Resident #1 was in his room. During his last round at 4:00 AM, he assumed Resident #1 was asleep and did not disturb him nor his roommate.</p> <p>Surveyor attempted to interview LVN I on 05/24/24 at 02:15 PM. Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record review of a Witness Statement dated 05/15/24 sent in by LVN I revealed, I went to Resident #1's room early morning on 05/14/24 to administer medications to his roommate, Resident #3. I noticed Resident #1's bed was unmade, and Resident #3 was sitting in his wheelchair asleep in front of the television. There was light on in the restroom, the water was running, and the restroom door was closed all the way. I allowed Resident #1 to have privacy in the restroom. I left the main door unlocked per the roommate's request then moved on to the next room to continue passing medications.</p> <p>2. Review of Resident #2's admission MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive status was moderately impaired, and he had hallucinations. He did not have wandering behaviors. His diagnoses included heart failure, diabetes, and Non-Alzheimer's Dementia, hemiplegia, and multiple sclerosis.</p> <p>Review of Resident #2's Order Summary Report for May 2024 reflected:</p> <p>04/24/24 Resident is wearing a wander guard device to the left ankle every shift for elopement.</p> <p>04/24/24 To ensure that wander guard is functioning correctly, every shift take resident to front door to ensure that alarm sounds. If alarm does not sound, please alert Administrator as soon as possible every shift for elopement.</p> <p>Review of Resident #2's Care Plans reflected:</p> <p>05/24/24 Resident is an elopement risk/wanderer related to dementia. Resident has a wander guard on his left ankle.</p> <p>Facility interventions included:</p> <p>Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.</p> <p>Identify pattern of wandering.</p> <p>Provide structured activities.</p> <p>Wander alert on left ankle. Monitor function and skin integrity every shift.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #2's Progress Notes reflected:</p> <p>05/21/24 5:46 PM Resident noted packing his clothing and stating, I'm leaving I'm going home. Writer attempted to redirect resident. Unable to redirect resident. Writer called family; resident calmed down after speaking with family. - LVN A</p> <p>05/22/24 2:30 PM Type: Behavior Note Resident insisted on leaving out the front door, despite receptionist attempts to redirect. Writer went outside and eventually was able to redirect resident to come back inside. Resident stated he wanted to go home. Called the wife and she said she was on the way. Resident appearing less agitated. - DON</p> <p>05/22/24 5:09 PM SW spoke with resident about wanting to leave today. Resident was very agitated, upset, angry, and verbally making threats towards people. Resident verbalized that he was upset over his cigarettes and not seeing his family. SW took resident outside to smoke and talk. Resident became very agitated again and began to pace and not listen to redirection. Resident would partially deescalate and then allow himself to amp up once again. Resident Mrs. [NAME] is aware of his behaviors and actions. SW sent referral to two facilities. - SW</p> <p>05/22/24 10:34 PM At approximately 7:27 PM alarm to the front door was sounding. Staff answered the alarm to discover resident was outside trying to leave the facility. Resident was stopped by staff and redirected back inside of facility. Resident placed on every 15-minute checks. - LVN A</p> <p>05/23/24 9:15 AM Resident continues this morning to attempt leaving. Redirecting this behavior is getting more difficult. - DON</p> <p>05/23/24 11:09 AM Late Entry</p> <p>Resident being sent to hospital for evaluation. Arranging transportation. - DON</p> <p>05/23/24 12:12 PM Resident noted with his belongings packed at the front door mentioning that he was leaving and didn't want to stay in this F** place no more, called the wife who is also the POA to talk to his and encourage him to wait for the social worker to get him another home, resident got very agitated and angry, threatening to leave any way notified the NP who gave an order to send resident to hospital, notified the wife transport arrived to pick up resident he refused to leave without all his belongings, cigarettes, bible, urinal he carried everything with him into the van, wife on the phone trying to convince him not to go with belongings resident was very adamant. Resident transported to hospital, Dr notified and DON aware. - ADON</p> <p>05/23/24 3:06 PM Resident returned from hospital at approximately 1:27 PM with no paperwork. Resident was alert, responsive, calm, and cooperative at that time. Resident ambulating with walker ab lib in hallways. Displays no distress. Denies any pain/discomfort. - LVN A</p> <p>05/23/24 10:24 PM The resident had a psych consult today with NP. New orders received to discontinue risperidone (used to treat schizophrenia) 2 and 3 mg and start risperidone 5 mg at bedtime, Depakote DR (anti-seizure medication and treats bipolar disorder) 250mg twice daily, change venlafaxine (anti-depressant) to every morning and a Valproic acid level and CBC 7 days after starting Depakote. - LVN A</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>05/25/24 3:01 PM Late Entry Resident forced himself out through the front door. Writer and another nurse ADON followed him and tried to redirect him, but resident did not want to listen or take directions. Resident was agitated and aggressive stating that he was going home. The ADON called resident's wife via video. Wife talked with the resident and asked him to come back into building. Wife told him that she will come to visit him today. Resident then came into the building. Resident redirected to his room. - LVN B</p> <p>05/26/24 2:02 PM Resident followed another resident through the front door and forced himself outside. Writer tried to redirect resident and bring him back to the building, but resident refused and aggressively pushed the doors and got out. Writer then walked with the resident. Resident stated that he was going home, and he wanted to go buy cigarettes. Writer told resident that he had some cigarettes in the box. Resident then stated that he needed to sit down for few minutes. Writer stayed with resident outside for about 20 minutes. Resident then decided to come back into the building. Resident walked to his room and laid down on his bed. - LVN B</p> <p>05/26/24 5:20 PM Writer asked the other staff member if they had seen the resident. CNA on duty stated that they were outside the smoke area with other residents, and he came back with other residents after the smoke break. Resident's walker noted at the dining hall, but resident is not there. Immediately all staff members alerted and started looking for the resident. All rooms searched but resident was not found. Administrator notified. Staff members went outside and searched around the building as some drove within the streets around, but resident was not found. Police notified and wife also called and notified. Staff members extended to search for the resident within the neighborhood, but resident was not found. Police arrived and were given description of the resident and gave the claim number. Police stated that if we find him before they do, we call them. - LVN B</p> <p>Review of Resident #2's Ambulance Record, dated 05/26/24, reflected:</p> <p>Dispatch notified: 7:31 PM</p> <p>On scene: 7:36 PM</p> <p>Resident transferred: 8:10 PM</p> <p>Patient was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. EMS arrived and transfer station staff were pouring water on him in an attempt to cool him off. EMS transported patient to the hospital.</p> <p>Review of Resident #2's Hospital Records, dated 05/26/24 8:30 PM, reflected:</p> <p>Chief Complaint: slurred speech, extremity weakness, fall, unable to respond to questioning. Temperature 98.9 degrees Fahrenheit.</p> <p>Final Diagnosis: Stroke</p> <p>Review of website: timeanddate.com on 05/29/24 reflected the following temperatures:</p> <p>[NAME] TX temperature:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 97 degrees</p> <p>Dallas TX temperature:</p> <p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 98 degrees</p> <p>An interview on 05/28/24 at 2:00 PM with a family member of Resident #2 revealed facility staff told her the resident was trying to leave the facility prior to his elopement. She said facility staff did not say he was on any enhanced monitoring. The family member said Resident #2 had tried to leave the previous facility he was in also. She said Resident #2 moved to the current facility because the facility had the wander guard system. The facility called her on 05/26/24 between 5:30 PM and 6:00 PM to tell her the resident had eloped. On 05/27/24 a person from the hospital called her and said the resident had been found and was in the hospital.</p> <p>An interview on 05/28/24 at 12:15 PM with the DON revealed she did not know how Resident #2 had eloped from the facility on 05/26/24. She said the resident was on 15-minute checks and provided a document showing 15-minute checks were completed and signed by staff. The DON said the resident kept attempting to get out of the facility and he was placed on a wander guard. She said the way the door worked was that if it was pressed on it would beep with the wander guard and then open. She said the resident was admitted on [DATE]. She said the facility staff noticed he was missing and began searching for the resident on 05/26/24. The DON said the resident was found in a gas station restroom and was taken to the hospital. The DON said the resident would not be returning to the facility. The DON said she had been working at the facility since 02/26/24.</p> <p>An interview on 05/28/24 at 12:40 PM with the Administrator revealed she said Resident #2 kept trying to get out and the staff were keeping him in sight. The Administrator said the resident forced himself out earlier when visitors were coming in and he was holding the door even though the alarm sounded, and staff had to tell him in to coming back again. The Administrator said Resident #2 was on 15-minute checks.</p> <p>Record review of the Resident Behavior Monitoring Log for Resident #2, dated 05-22-24 to 5-26-24 and provided by the DON, reflected 15-minute checks were documented and each entry was signed. The form showed LVN B's initials were signed for each entry on 05/26/24 from 6:00 AM to 5:45 PM.</p> <p>An interview on 05/29/24 at 9:45 AM with LVN B revealed he last saw Resident #2 on 04/26/24 at 4:00 PM when he went out to smoke. His initials were on the 15-minute checks provided by the DON. He said he went back to passing medications and noticed the resident's walker was in the front area next to the kitchen. LVN B said he did not perform 15-minute monitoring checks and also did not sign a form saying that he did. He said the resident was on hourly checks. He said he was the charge nurse, and the other staff were also not performing 15-minute checks on the resident.</p> <p>An interview on 05/29/24 at 11:06 AM with CNA C revealed she worked on 05/26/24 and last saw Resident #2 after smoke break between 4:00 PM and 4:30 PM. She said she was not checking on the resident every 15 minutes. She said she checked on the resident every hour.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An interview on 05/29/24 at 11:55 AM with CNA D revealed she last saw Resident #2 on 05/26/24 after [TRUNCATED]</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure residents receives adequate supervision and assistance devices to prevent accidents for two of nine residents (Resident #1 and Resident #2) reviewed for elopement.</p> <p>1. The facility failed to ensure Resident #1 was adequately supervised to prevent him from leaving the facility. Resident #1 had access to the door code for the front door although he had impaired cognitive function or thought processes related to Dementia and lacked safety awareness. Resident #1 eloped from the facility on 05/14/23 and was arrested the same day 3.5 miles away for impeding the progress of a southbound public train.</p> <p>2. The facility failed to ensure Resident #2 was supervised adequately and did not elope from the facility. Resident #2 was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. Resident #2 suffered a stroke and was hospitalized .</p> <p>An Immediate Jeopardy (IJ) was identified on 5/29/24 at 3:20 PM. The IJ template was provided to the facility on [DATE] 3:25 PM and signed by the Administrator. While the IJ was removed on 05/31/24 the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of pattern due to the facility still monitoring the effectiveness of their Plan of Removal.</p> <p>These failures resulted in one arrest due to obstructing traffic and one hospitalization due to being found lying on the ground and had suffered a stroke.</p> <p>Findings included:</p> <p>1. Review of Resident #1's quarterly MDS assessment, dated 05/02/24, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), epilepsy (abnormal electrical brain activity), muscle weakness, lack of coordination and anxiety (feeling of fear, dread, and uneasiness). The MDS reflected Resident #1 had a BIMS (Brief Interview for Mental Status - is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 10 indicating moderate cognitive impairment, moderately impaired decision-making, required cues/supervision. Under Section P - Restraints and Alarms revealed Resident #1 did not have any physical restraints (wander guard). Resident #1's undated Census Record reflected a discharge date of [DATE].</p> <p>Review of Resident #1's care plan revised on 05/08/24 revealed Resident #1 had an ADL (activities of daily living) self-care performance deficit related to activity intolerance, confusion, impaired balance was addressed. Interventions included encourage the resident to use the call light for assistance, he required extensive assistance x 1 staff for toileting and praise all efforts at self-care.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's quarterly Elopement Risk Assessments, dated 02/12/24 and 05/12/24, revealed Resident #1 was ambulatory and had no history of wandering. The assessment reflected the Resident #1 was at a low risk for wandering with a score of 2.0 and had no reported episodes of wandering in the past 6 months.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 10:09 AM written by LVN J revealed the resident is not in the building, his roommate said, he left at 1:30 AM and he has not come back.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 11:30 AM written by SW revealed there were several groups of staff that went out looking for Resident #1 to find him. The groups returned unable to locate him.</p> <p>Review of Resident #1's progress notes dated 05/14/24 at 1:30 PM written by SW revealed DPD notified the ADM that Resident #1 had been found in [. Jail]. SW called [. Jail] to find him and they were unable to locate him either in jail or in booking. SW then looked up Resident #1 in [. County Jail] and was able to find that Resident #1 had been picked up at 11:01 AM on 05/14/24 due to Obstruction of Highway Passageway.</p> <p>Review of the Provider Investigation Report dated 05/21/24 revealed Resident #1 was last seen on 05/13/24 at 8:30 PM in his room when taking his evening medications. On 05/14/24, CNA L served his breakfast tray at 08:30 AM and Resident #1 could not be found after searching inside the facility. DPD was notified on 05/14/24 of missing resident and was provided with a photo and face sheet. It further stated it was confirmed Resident #1 left the facility without anyone observing him, nor him notifying anyone and Resident #1 had been given the door code by another resident to go outside and smoke off property.</p> <p>Review of Resident #1's Smoking Safety Screen dated 02/01/24 and 05/01/24 revealed due to his diagnosis of dementia, Resident #1 was a supervised smoker.</p> <p>Review of in-service training dated 05/14/24, after Resident #1's elopement, revealed training related to the procedure to follow when a resident was missing. The in-service did not address elopement prevention, ensuring wander-guard transmitters were routinely tested /checked to ensure they were functioning properly or training to ensure staff were able to demonstrate competency in monitoring and checking wander-guard transmitters.</p> <p>Review of DTP Police Report dated 05/14/24 revealed Resident #1 was arrested on Tuesday, 05/14/24 at approximately 08:30 AM . impeding the progress of a southbound [Company] train.</p> <p>Interview with a family member of Resident #1 on 05/23/24 at 9:45 AM she stated the SW called her on 05/14/24 and informed her Resident #1 was missing. Resident #1's family member stated she had not spoken to, nor visited Resident #1 since November 2023. Resident #1's family member stated they had not found Resident #1, and the SW stopped communicating with her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the ADM on 05/23/24 at 10:30 AM she stated due to Resident #1 not being exit-seeking, he did not wear a wander-guard transmitter. The ADM stated during their morning meeting on 5/14, it was reported by LVN J they were unable to locate Resident #1 inside the facility. The ADM stated LVN J informed her CNA L delivered Resident #1's breakfast tray to his room and then took residents out to smoke at 8:30 AM, but Resident #1 did not partake in neither. The ADM stated a report was filed with the DPD and a couple of hours later she was informed by DPD that Resident #1 was no longer considered missing as he had been arrested.</p> <p>Interview with the DON on 05/23/24 at 10:40 AM she stated Resident #1 had not experienced a medical decline. The DON stated she believed Resident #1 had the door code because the only way you can get out without sounding the alarm, you would have to enter the door code. The DON stated Resident #1 had Dementia, but you would not know it by talking to him or looking at him.</p> <p>Interview with Resident #3 (Resident #1's roommate) on 05/23/24 at 12:00 PM, he stated Resident #1 did not tell him he was leaving. Resident #3 stated he awakened around 01:00 AM and Resident #1 was not in his bed. Resident #3 stated Resident #1 never mentioned he wanted to leave. Resident #3 stated all Resident #1 did was smoked and visited other residents. Resident #3 stated Resident #1 never showed any signs that he wanted to leave or that he did not like it here.</p> <p>Interview with Resident #4 (Resident #1's friend) on 05/23/24 at 12:20 PM, he stated Resident #1 followed him outside and on occasion might had seen him enter the door code to get out. Resident #4 denied intentionally providing the door code to Resident #1.</p> <p>Interview with DET A on 5/23/24 at 01:35 PM, he stated it appeared Resident #1 had been arrested in Waxahachie, but later confirmed he had been arrested by the [Agency] Police. DET A stated when he started his search for Resident #1, he was not deemed missing as he had already been arrested. DET A stated his case was closed as Resident #1 was no longer considered a missing person.</p> <p>Interview with the MD on 5/23/24 at 01:50 PM, he stated he was notified by the facility on 05/14/24 that Resident #1 eloped, and the police picked him up. The MD stated Resident #1 had never eloped before and did not exhibit any exit-seeking behaviors. The MD stated Resident #1 had not had any change in conditions. The MD stated Resident #1 ambulated independently.</p> <p>Interview with LVN H on 5/23/24 at 02:35 PM, she stated she worked on Monday, 5/13 from 2:00 PM until 10:00 PM. LVN H stated she administered Resident #1's medication before the regular smoke break at 8:00 PM. LVN H stated she saw Resident #1 return to his room after he finished smoking. LVN H stated she never saw Resident #1 come out of his room before she ended her shift at 09:50 PM. LVN H stated Resident #1 was his normal self and had not had a change in condition. LVN H stated staff was not supposed to give the door code to any residents. LVN H stated now the door codes would be changed monthly by the MTD. LVN H stated you had to make sure the door closed and locked and not allow any residents to exit behind you. LVN H stated the Residents that previously had the door code, had to be assessed by the SW. LVN H stated if a Resident passed the Mental Mini-Assessment, they were allowed to sign themselves in and out. LVN H stated if you were unable to locate a resident, you would notify the ADM. LVN H stated then the ADM would instruct management to drive around the neighborhood and if they still could not find the resident, the police would be notified. LVN H stated if the resident were found, they would complete an assessment, an incident report and notify the doctor and the family. LVN H stated if the doctor gave an Order for a wander guard, they would place a wander guard on the resident. LVN H stated Resident #1 was not a wanderer.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with CNA K on 5/23/24 at 02:50 PM, he stated he saw Resident #1 the day prior on Monday (5/13). CNA K stated there were no concerns. CNA K stated Resident #1 walked throughout the facility independently and went outside to smoke. CNA K stated the next morning on 5/14/24, he had not seen Resident #1 up and walking around when he delivered his breakfast tray to his room. CNA K stated when he arrived at Resident #1's room approximately 07:50 AM, Resident #1 was not in his room. CNA K stated he told CNA L that Resident #1 was not in his room, and CNA L said to leave his breakfast tray because Resident #1 had probably gone outside to smoke. CNA K stated he then told LVN J that Resident #1 was not in his room, and LVN J said he probably had gone outside to smoke too. CNA K stated approximately 9:00 AM, Resident #1 had not come out to smoke, and they started searching for him inside and outside the facility. CNA K stated you were supposed to check on residents every 2 hours, but it had now been changed to every one hour. CNA K stated when you completed the checks, you had to chart in PCC any care provided. CNA K stated if you just laid eyes on a Resident only, you do not have to enter anything in PCC. CNA K stated you must now check residents off on the Rounding List, but only after physically laying eyes on them. CNA K stated he had never known for a resident to go missing. CNA K stated previously residents authorized to enter and exit with the door code, had the freedom to go as they pleased if they signed in and out. CNA K stated the MTD changed the door code, and it would now be changed monthly and only employees are allowed the code. CNA K stated whenever an employee enters or exits the facility, they must make sure the door was closed to prevent any resident from following them out.</p> <p>Interview on 05/23/24 at 03:05 PM, the ADON stated Resident #1 was quiet and kept to himself. The ADON stated Resident #1 was usually alert and oriented. The ADON stated on the morning of 05/14/24, LVN J stated Resident #1 was not in his room or the common areas. The ADON stated the Management drove throughout the community searching for Resident #1. The ADON stated the ADM called DPD and Resident #1 was located in jail. The ADON stated Resident #1 had been arrested for obstructing traffic. The ADON stated each Resident must complete a Mini Mental Exam and depending on their score determines if they are allowed to sign themselves in and out, smoke unsupervised, or leave the facility without a family member. The ADON stated she did not know if anything could have been done differently because Resident #1 was not a wanderer, and he caught the facility off guard. The ADON stated any resident that leaves the facility must sign out and inform the nurse. The ADON stated aides and nurses completes rounds every hour. The ADON stated Resident #1 could had been hit by a vehicle, ended up in the hospital, or even killed.</p> <p>Interview with the ADM on 05/23/24 at 03:25 PM, she stated they had completed re-assessments on all residents to ensure the assessments were accurate. The ADM stated all exit-seeking residents had a doctor's order to wear a wander guard. The ADM stated the SW reassessed the residents that are allowed to sign themselves out. The ADM stated the DON completed in-services with staff on 05/14/24 on rounding with each other and not by themselves. The ADM stated now nurses had to print out the Midnight Census Report, give the report to the DON and text the ADM the headcount at midnight. The ADM stated they spoke with all residents approved to sign themselves out and informed them they must notify staff and make sure they sign in and out. The ADM stated they would have another in-service tomorrow on 05/24/24 to discuss the same items.</p> <p>During an observation on 05/24/24 at 10:30 AM, Surveyor observed several Residents across from the entrance sitting in the dining area waiting to play bingo. The residents all denied being provided or knowing the door code to exit the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with the SW on 05/24/24 at 11:00 AM, she stated Resident #1 did not have any change of conditions leading up to the elopement. The SW stated she drove throughout the neighborhood and could not locate Resident #1. The SW stated she searched for Resident #1 on the DPD website and confirmed that Resident #1 had been arrested for obstructing a highway passageway. The SW stated Resident #1 was not exit-seeking and did not wear a wander guard. The SW stated on 5/22/24 at 10:21 AM, Resident #1's daughter called her to get an update because she could not get through to the jail. The SW stated she looked Resident #1 up again on the DPD's website and it showed Resident #1 had been released the day prior on 5/21. The SW stated she drove downtown, around the jail and where the homeless people congregate and did not see Resident #1. The SW stated Resident #4 was allowed to sign himself in and out and exit the facility using the door code. The SW stated Resident #1 was not allowed the door code due to his dementia diagnosis. The SW stated Resident #4 did not admit to giving Resident #1 the door code but suggested Resident #1 may have witnessed him entering it, or he may have given it to Resident #1 to enter.</p> <p>Interview with LVN J on 05/24/24 at 01:20 PM, she stated she arrived to work late on 05/14/24. She stated while completing her rounds on 05/14/24 around 08:00 AM, she did not see anyone in Resident #1's room. LVN J stated this was around the time Resident #1 goes to smoke. LVN J stated after she completed her rounds, she went to receive the shift change report from the night nurse, LVN I. LVN J stated she went back to Resident #1's room to give him his medication, but he was not back. LVN J stated she checked the bathroom, and no one was in there. LVN J stated she went ahead and asked Resident #3 (roommate), and he responded, Resident #1 went out last night and he never came back. LVN J stated she asked CNA L if she had seen Resident #1 and she responded she had not seen him. LVN J stated she went to check his usual places, his friends' rooms and the smoking area and he was not there. LVN J stated she checked if Resident #1 signed himself out, but his name was not in the binder. LVN J stated she then requested all the CNAs to check every room, but Resident #1 was not found. LVN J stated she then reported the information to the ADM. LVN J explained the old process for completing rounds was you would go to each room but did not have to sign anything. LVN J stated the new process had changed to hourly checks and if you arrive to a room and if the resident was not there you must look for them immediately. LVN J stated staff must now complete 15-minute door checks and someone would be stationed at the front desk 24-hours day. LVN J stated if someone were at risk for elopement you must complete an elopement assessment and the results would confirm if the resident was at risk. LVN J stated she would then inform the ADM, DON, and the ADON. LVN J explained the process for wander guards are each day on every shift, you must check to see if the wander guard was working. LVN J stated if the wander guard was not working properly, you must report it to the MD, the ADM, and the DON. LVN J stated if the wander guard were working properly, the light would be red, and it makes a continuous sound if a resident gets too close to the door. LVN J stated the alarm would have to be physically turned off at the nursing station. LVN J stated she was trained by the DON to take residents with wander guards to the front door to ensure the equipment was working properly. LVN J stated residents are not allowed to have the door code and staff must open the door for them to enter and exit the facility. LVN J stated she received a new door code, and the door code would now be changed monthly. LVN J stated Resident #1 could have been harmed, hit by a car, or even killed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Interview with CNA L on 05/24/24 at 01:40 PM, she stated when she arrived to work 05/14/24 at 6:00 AM, she completed her rounds noticed Resident #1 was not in his room and his bed was made. CNA L stated when the breakfast trays arrived on the floor at approximately 8:30 AM, CNA K took Resident #1 his breakfast tray, and he was still not in his room. CNA L stated LVN J asked her if Resident #1 were in his room when she completed her rounds and she stated, No. CNA L stated her, and CNA K searched the inside and outside of the facility and could not located Resident #1. CNA L stated the process for completing rounds did not have a checklist at the time. CNA L stated you would inform the nurse if there were any concerns. CNA L stated now there was a checklist. CNA L stated if a resident was not in their room, they must search all rooms and they cannot wait and assume the resident was smoking. CNA L stated now CNAs complete rounds every odd hour and Nurses complete rounds every even numbered hour. CNA L stated since the elopement, if any resident signs themselves out to smoke and if the resident was not back within 15 minutes, staff must check on them. CNA L stated she had two residents on her hall that wears a wander guard, and she must check the wander guard by observing the light taking and take the resident to the door to sound the alarm. CNA L stated she must then sign the wander guard binder at the front desk. CNA L stated there was a sign-out binder for residents to sign out and staff must escort the resident to the door. CNA L stated staff was not allowed to share the door code with anyone. CNA L stated she was unsure how the residents previously received access to the door code. CNA L stated prior to this incident, Resident #1 had never tried to elope.</p> <p>Surveyor attempted to interview CNA M on 05/24/24 at 02:00 PM. Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record Review of a Witness Statement dated 05/15/24 by CNA M revealed, I clocked in and walked my halls at 10:00 PM. Resident #1 was in his room. At approximately 11:00 PM, Resident #1 received ice. At midnight, Resident #1 was in his room. At 2:00 AM, another round was completed, and Resident #1 was in his room. During my last round at 4:00 AM, I assumed Resident #1 was asleep and did not disturb him nor his roommate.</p> <p>Surveyor attempted to interview LVN I on 05/24/24 at 02:15 PM. Surveyor left a voicemail and sent a text requesting a callback.</p> <p>Record Review of a Witness Statement dated 05/15/24 sent in by LVN I revealed, I went to Resident #1's room early morning on 05/14/24 to administer medications to his roommate, Resident #3. I noticed Resident #1's bed was unmade, and Resident #3 was sitting in his wheelchair asleep in front of the television. There was light on in the restroom, the water was running, and the restroom door was closed all the way. I allowed Resident #1 to have privacy in the restroom. I left the main door unlocked per the roommate's request then moved on to the next room to continue passing medications.</p> <p>2. Review of Resident #2's admission MDS assessment dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His cognitive status was moderately impaired, and he had hallucinations. He did not have wandering behaviors. His diagnoses included heart failure, diabetes, and Non-Alzheimer's Dementia, hemiplegia, and multiple sclerosis.</p> <p>Review of Resident #2's Order Summary Report for May 2024 reflected:</p> <p>04/24/24 Resident is wearing a wander guard device to the left ankle every shift for elopement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>04/24/24 To ensure that wander guard is functioning correctly, every shift take resident to front door to ensure that alarm sounds. If alarm does not sound, please alert Administrator as soon as possible every shift for elopement.</p> <p>Review of Resident #2's Care Plans reflected:</p> <p>05/24/24 Resident is an elopement risk/wanderer related to dementia. Resident has a wander guard on his left ankle.</p> <p>Facility interventions included:</p> <p>Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book.</p> <p>Identify pattern of wandering. Provide structured activities.</p> <p>Wander alert on left ankle. Monitor function and skin integrity every shift.</p> <p>Review of Resident #2's Elopement Assessment, dated 05/22/24 revealed the resident was ambulatory, had a history of wandering, and diagnosis of dementia/cognitive impairment. The assessment reflected the resident was at a high risk for wandering with a score of 13.0.</p> <p>Review of Resident #2's Progress Notes reflected:</p> <p>05/21/24 5:46 PM Resident noted packing his clothing and stating, I'm leaving I'm going home. Writer attempted to redirect resident. Unable to redirect resident. Writer called family; resident calmed down after speaking with family. - LVN A</p> <p>05/22/24 2:30 PM Type: Behavior Note Resident insisted on leaving out the front door, despite receptionist attempts to redirect. Writer went outside and eventually was able to redirect resident to come back inside. Resident stated he wanted to go home. Called the wife and she said she was on the way. Resident appearing less agitated. - DON</p> <p>05/22/24 5:09 PM SW spoke with resident about wanting to leave today. Resident was very agitated, upset, angry, and verbally making threats towards people. Resident verbalized that he was upset over his cigarettes and not seeing his family. SW took resident outside to smoke and talk. Resident became very agitated again and began to pace and not listen to redirection. Resident would partially deescalate and then allow himself to amp up once again. Resident Mrs. [NAME] is aware of his behaviors and actions. SW sent referral to two facilities. - SW</p> <p>05/22/24 10:34 PM At approximately 7:27 PM alarm to the front door was sounding. Staff answered the alarm to discover resident was outside trying to leave the facility. Resident was stopped by staff and redirected back inside of facility. Resident placed on every 15-minute checks. - LVN A</p> <p>05/23/24 9:15 AM Resident continues this morning to attempt leaving. Redirecting this behavior is getting more difficult. - DON</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>05/23/24 11:09 AM Late Entry Resident being sent to hospital for evaluation. Arranging transportation. - DON</p> <p>05/23/24 12:12 PM Resident noted with his belongings packed at the front door mentioning that he was leaving and didn't want to stay in this F** place no more, called the wife who is also the POA to talk to his and encourage him to wait for the social worker to get him another home, resident got very agitated and angry, threatening to leave any way notified the NP who gave an order to send resident to hospital, notified the wife transport arrived to pick up resident he refused to leave without all his belongings, cigarettes, bible, urinal he carried everything with him into the van, wife on the phone trying to convince him not to go with belongings resident was very adamant. Resident transported to hospital, Dr notified and DON aware. - ADON</p> <p>05/23/24 3:06 PM Resident returned from hospital at approximately 1:27 PM with no paperwork. Resident was alert, responsive, calm, and cooperative at that time. Resident ambulating with walker ab lib in hallways. Displays no distress. Denies any pain/discomfort. - LVN A</p> <p>05/23/24 10:24 PM The resident had a psych consult today with NP. New orders received to discontinue risperidone (used to treat schizophrenia) 2 and 3 mg and start risperidone 5 mg at bedtime, Depakote DR (anti-seizure medication and treats bipolar disorder) 250mg twice daily, change venlafaxine (anti-depressant) to every morning and a Valproic acid level and CBC 7 days after starting Depakote. - LVN A</p> <p>05/25/24 3:01 PM Late Entry Resident forced himself out through the front door. Writer and another nurse ADON followed him and tried to redirect him, but resident did not want to listen or take directions. Resident was agitated and aggressive stating that he was going home. The ADON called resident's wife via video. Wife talked with the resident and asked him to come back into building. Wife told him that she will come to visit him today. Resident then came into the building. Resident redirected to his room. - LVN B</p> <p>05/26/24 2:02 PM Resident followed another resident through the front door and forced himself outside. Writer tried to redirect resident and bring him back to the building, but resident refused and aggressively pushed the doors and got out. Writer then walked with the resident. Resident stated that he was going home, and he wanted to go buy cigarettes. Writer told resident that he had some cigarettes in the box. Resident then stated that he needed to sit down for few minutes. Writer stayed with resident outside for about 20 minutes. Resident then decided to come back into the building. Resident walked to his room and laid down on his bed. - LVN B</p> <p>05/26/24 5:20 PM Writer asked the other staff member if they had seen the resident. CNA on duty stated that they were outside the smoke area with other residents, and he came back with other residents after the smoke break. Resident's walker noted at the dining hall, but resident is not there. Immediately all staff members alerted and started looking for the resident. All rooms searched but resident was not found. Administrator notified. Staff members went outside and searched around the building as some drove within the streets around, but resident was not found. Police notified and wife also called and notified. Staff members extended to search for the resident within the neighborhood, but resident was not found. Police arrived and were given description of the resident and gave the claim number. Police stated that if we find him before they do, we call them. - LVN B</p> <p>Review of Resident #2's Ambulance Record, dated 05/26/24, reflected:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Dispatch notified: 7:31 PM</p> <p>On scene: 7:36 PM</p> <p>Resident transferred: 8:10 PM</p> <p>Patient was found lying on the ground at the transfer station for 30 minutes prior to EMS arrival. EMS arrived and transfer station staff were pouring water on him in an attempt to cool him off. EMS transported patient to the hospital.</p> <p>Review of Resident #2's Hospital Records, dated 05/26/24 8:30 PM, reflected:</p> <p>Chief Complaint: slurred speech, extremity weakness, fall, unable to respond to questioning. Temperature 98.9 degrees Fahrenheit.</p> <p>Final Diagnosis: Stroke</p> <p>Review of website: timeanddate.com on 05/29/24 reflected the following temperatures:</p> <p>[NAME] TX temperature:</p> <p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 97 degrees</p> <p>Dallas TX temperature:</p> <p>5/26/24 4:53 PM 97 degrees</p> <p>5/26/24 6:53 PM 98 degrees</p> <p>Observation of Resident #2 on 05/25/25 at 1:20 PM revealed the resident was wearing a wander-guard transmitter on the left lower extremity and the presence of the LED light indicated it was functional.</p> <p>Observation of Resident #2 on 05/25/24 at 03:15 pm revealed the DM sitting one-on-one with Resident #2 in the facility's lobby with his wander-guard transmitter still visible on the left lower extremity and the presence of the LED light indicated it was functional.</p> <p>An interview on 05/25/24 at 01:00 PM with the MTD he stated he adjusted the front door to make the door close faster and changed the door code. The MTD stated the front door was monitored by the wander-guard system. The MTD stated normally, [Company] instructed him over the phone how to change the door code, but this time, he had [Company] come to the facility and [Company] installed a button under the receptionist's desk in order to open the door remotely and provided him a manual on how to change the door code himself. The MTD stated there had not been any concerns and everything was working properly. The MTD stated he monitored the doors as needed to ensure they are closing properly. The MTD stated he completed door checks three times a day and completed Tail Logs for documentation purposes. The MTD stated he had never been aware of any residents being in possession of the door code.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER South Dallas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3808 S Central Expwy Dallas, TX 75215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 05/25/24 at 01:20 PM, Surveyor observed the five residents identified for placement of a Wander Guard. Surveyor observed the five residents in their rooms with their Wander Guard placed according to their individual Care Plans and Orders. Surveyor also conducted testing with the ADON at the front door to ensure the Wander Guards were functioning properly.</p> <p>An interview on 05/25/24 at 02:15 PM, with the DM, he stated he drove around looking for Resident #1 when he was reported missing. The DM stated he was in-serviced on not giving the door code out or allowing residents to follow anyone outside. The DM stated the door codes were changed and a remote access button was installed under the receptionist's desk.</p> <p>An interview on 05/25/24 at 02:30 PM, with HR, she stated she was in-serviced on making sure all residents know they must be buzzed in and out. HR stated no residents nor visitors should have access to the door code. HR stated the approved residents must sign in and out of the facility and let staff know they are leaving. HR stated the MTD changed the door codes last on Thursday, 05/23/24. HR stated when she ends her shift at 5:00 PM and over the weekend, various staff members would cover the front door.</p> <p>An interview on 05/25/24 at 02:45 PM, HK O stated she was in-serviced on being more concerned when entering and exiting the front door. HK O stated she was informed the door code would be changed once a month. HK O stated she was informed to keep an eye on the residents that wear a Wander Guard.</p> <p>Interviews were conducted with facility staff across multiple shifts on 05/23/24, 05/24/24, and 05/25/24. Staff interviewed were LVN H, LVN J, CNA L, CNA K, CNA F, CNA G, CNA C, HK O, LVN B, LVN J and MA A.</p> <p>Interviews with the staff revealed they verbalized comprehension of the in-service training. They stated they had been in-serviced on obtaining orders when a resident was assessed and determined to require a wander guard to ensure the wander guard monitoring populated into the TARS. They stated they had been in-serviced on checking to ensure the wander guard was functional every shift by observing that the light was visible and taking residents to the front door to ensure the alarm sounded. Staff verbalized the wander guard could only be monitored and checked at the front door and they stated if they saw a resident with a wander guard, they would ensure there were orders and monitoring in the clinical record. All were aware to notify the ADON, DON, or ADM for any [TRUNCATED]</p>		