

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675603	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Rose Haven Retreat		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Live Oak St Atlanta, TX 75551	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47006</p> <p>Based on observations, interviews, and record review the facility failed to ensure the resident environment remained free of accident hazards as possible, and each resident received adequate supervision to prevent elopement for 1 of 18 residents (Resident #1) reviewed for accident hazards and supervision.</p> <p>The facility failed to prevent Resident #1 from eloping (leaving the facility property) from the secured unit on 02/10/25.</p> <p>The noncompliance was identified as PNC. The IJ began on 02/10/25 and ended on 02/10/25. The facility had corrected the noncompliance before the survey began.</p> <p>This failure could place the residents at risk for serious injury, serious harm, serious impairment, or death.</p> <p>The findings included:</p> <p>Record review of the face sheet, undated, reflected Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of unspecified dementia (memory loss), anxiety disorder (intense feelings of anxiety and fear that can interfere with daily activities), restlessness and agitation, delusional disorder (type of psychotic disorder that involves having unshakable belief in something not true), and unspecified convulsions (seizures).</p> <p>Record review of the quarterly MDS assessment, dated 01/22/25, reflected Resident #1 had clear speech and was understood by others. The MDS reflected Resident #1 was able to understand others. The MDS reflected Resident #1 had a BIMS score of 6, which indicated severely impaired cognition. The MDS reflected Resident #1 had inattention and disorganized thinking that was continuously present and did not fluctuate. The MDS reflected Resident #1 had no behaviors. The MDS reflected Resident #1 was independent with indoor mobility that included ambulation (walking) and used no assistive devices.</p> <p>Record review of the comprehensive care plan, updated on 02/10/25, reflected Resident #1 was at risk for elopement and exhibited wandering behaviors. The interventions included: one-to-one observations that started on 02/10/25 and resolved on 02/15/25; and provide comfort measures for basic needs if Resident #1 begins to wander, such as pain, hunger, toileting, too hot/cold.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the physician order report, dated 01/25/25 to 02/25/25, reflected Resident #1 had an order which started on 01/20/2025 for Resident #1 to admit to the facility on the secured unit related to elopement risk.</p> <p>Record review of the elopement risk assessment, dated 08/28/24, reflected Resident #1 had a score of 24. The scoring criteria stated if a resident had a score of 10 or more, the resident was at risk for elopement.</p> <p>Record review of the skilled daily nurses note, dated 02/10/25, reflected Resident #1 exhibited wandering behaviors on the evening shift. The narrative, timed at 4:40 PM, stated [RN A] came from front when stopped by [BOM] asking where resident is. Resident had eloped and went outside down the road and fell . EMS called for evaluation - taken to ER. Resident awake and alert, oriented to baseline at time of incident. DON notified, RP notified, Administrator notified. The narrative timed at 8:45 PM, stated Resident returns to locked unit via facility van accompanied with staff. Ambulatory, alert to baseline. Contusion to right forehead and 2 scabs on right ear. No new orders per ER doctor. Add: Abrasion on right forehead, 2 scabs with bruising on right ear. Small bruise on right upper extremity, small scabbed over abrasion on left knee.</p> <p>Record review of the incident report, dated 02/10/25, reflected Resident #1 was found outside the facility and had an unwitnessed fall. The incident report reflected Resident #1 was alert and had head involved contusions/hematomas. The narrative stated [RN A] was getting blood sugar levels from front residents. [CNA B] in shower with another resident. Received a call from [BOM] stating resident had eloped. Resident returned to facility. EMS here to assess resident, sent to ER for evaluation and treatment.</p> <p>Record review of CNA B's witness statement, dated 02/10/25, reflected I was giving a shower during time of incident - I wasn't aware of incident. I did give him [Resident #1] a snack and orange juice in the dining room at 4:30 PM. Watching television.</p> <p>Record review of RN A's witness statement, dated 02/10/25, reflected This resident last seen by this nurse approximately 3 PM - 3:30 PM while getting vital signs. This nurse had to leave secured unit to go check blood sugars on other residents under this nurse's care. Arrived back on secured unit to [BOM] asking if I had seen resident. Resident found outside, doctor states to send resident to ER.</p> <p>Record review of Sitter C's witness statement, dated 02/10/25, reflected I didn't see what happened. The last time I saw him [Resident #1] was when I came in at 2 PM. I've been doing one-on-one with [another resident].</p> <p>Record review of the provider investigation report, signed 02/17/25, reflected the facility immediately returned Resident #1 to the facility and assessed for injury. Resident #1 was sent to the ER for evaluation and treatment. The facility immediately performed a head count, and all other residents were accounted for. The facility checked all alarms and exit-doors to ensure they were functioning properly. The facility performed a psycho-social assessment on Resident #1 and resident safe surveys. The facility provided in-service education on abuse, neglect, and exploitation, elopement, alarms, door codes, and using exit doors on the secured unit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's ER paperwork, dated 02/10/25, reflected Resident #1 was seen in the emergency department for an abrasion on forehead after a fall. No significant findings were identified.</p> <p>Record review of the daily census report, dated 02/10/25, reflected a note that stated the BOM performed a head count of all 46 residents in the facility. All residents were accounted for.</p> <p>Record review of a signed statement, dated 02/10/25, reflected All doors and door alarms were checked and found to be in working order by myself [Administrator] and nurse's [RN D] and [RN A].</p> <p>Record review of the psycho-social assessment, dated 02/10/25, reflected Resident #1 had a BIMS score of 3, which indicated severe cognitive impairment. The assessment reflected Resident #1 had delusions (misconceptions or beliefs that are firmly held, contrary to reality). The assessment reflected Resident #1 was oriented to self and had poor memory in the present. The assessment reflected Resident #1 was anxious, agitated, and depressed at times. The assessment reflected Resident #1 wandered, was verbally abusive, physically abusive, and social inappropriate at times.</p> <p>Record review of the resident safe surveys, dated 02/10/25, reflected no significant findings.</p> <p>Record review of the in-service record dated 2/10/25 reflected education was provided on abuse policy and procedure. There were approximately 61 signatures.</p> <p>Record review of the in-service record dated 2/10/25 reflected education was provided on elopement to include procedure if elopement occurs. There were approximately 61 signatures.</p> <p>Record review of the in-service record dated 2/10/25 reflected education was provided on answering alarms and investigating source of alarms. There were approximately 61 signatures.</p> <p>Record review of the in-service record dated 2/10/25 reflected education was provided on exit doors to include not using them to enter and exit the building. Ensuring they are enabled and alarmed at all times. There were approximately 61 signatures.</p> <p>Record review of the in-service record dated 2/10/25 reflected education was provided on red box alarm keys to include location and sign out procedures. There were approximately 40 signatures.</p> <p>During an observation and interview on 02/20/25 beginning at 10:53 AM, Resident #1 was sitting up in the dining room. Resident #1 had bruising to his right eye. Resident #1 stated he had fallen across the street, but he was doing okay. Resident #1 was unable to give any further details of the incident on 02/10/25 as he was confused during the conversation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/20/25 beginning at 11:46 AM, RN A stated on 02/10/25 she was the nurse assigned to the back secured unit, but she was also assigned residents in the front halls. RN A stated she was at the front getting blood sugars at approximately 4 PM - 4:30 PM. RN A stated when she returned to the secured unit, she was confronted by the BOM who asked her if she knew Resident #1 was missing. RN A stated she had no idea Resident #1 was missing and had not heard any alarms because she was at the front of the building. RN A stated the BOM stated she had received a call that Resident #1 was walking down the road. RN A stated she went to look for Resident #1 and found him down the road from the facility at a couple houses next door. RN A stated he was off the premises. RN A stated Resident #1 was standing up when she found him. RN A stated Resident #1 had apparently gotten hurt because he had an abrasion to his right eyebrow and right ear. RN A stated when Resident #1 returned to the facility, he was assessed and treated for his wounds. RN A stated Resident #1 was sent to the ER just to be sure because the fall was un-witnessed. RN A stated Resident #1 exhibited exit-seeking behaviors often. RN A stated staff used to use the exit-doors to the secured unit, but they were unable to use them since the incident with Resident #1. RN A stated after Resident #1 was sent to the ER, she checked the doors on the secured unit. RN A stated the back door, off the hallway had a keypad that was blinking green and red repetitively and the door was unlocked. RN A stated she reported the door to the Administrator and the maintenance staff were in that day to fix it. RN A stated she had noticed the keypad doing that before and had mentioned it to the management staff. RN A stated after the incident with Resident #1 the facility staff repaired the door, implemented 15-minute door checks, changed the door codes, and provided in-service education to staff on not using the side doors, ensuring red box alarms were turned on and functioning, abuse and neglect, and elopement policy and procedures.</p> <p>During an observation and interview on 02/20/25 beginning at 2:05 PM, the BOM stated she received a call from her friend who lives a few houses down, saying I think you have a resident out. The BOM stated her friend described the resident and she felt like it sounded like Resident #1, so she alerted the nurse and ran out the back door. The BOM stated as she was running out the back door, RN A was coming from the secured unit and they found Resident #1, escorted him back to the facility, and called EMS. The BOM assisted surveyor to the back parking lot and pointed out a mailbox and house approximately 150 feet from the back parking lot. The BOM stated that was where Resident #1 was found. The road ran in front of residential housing and the speed limit was 30 miles per hour. There were lightly wooded areas near the house.</p> <p>During an interview on 02/20/25 beginning at 2:17 PM, the Administrator stated she had just left the facility when she received a phone call from the BOM saying Resident #1 had gotten out. The Administrator stated she turned around and came back to the facility. The Administrator she had discovered Resident #1 received a small abrasion and was sent to the ER, he returned to the facility later that night before she had left. The Administrator stated the facility staff placed Resident #1 on frequent monitoring, changed the alarm codes, checked doors and alarms, performed a head count. The Administrator stated there was an issue with the keypad on the back door but it was fixed immediately. The Administrator stated they were unsure how Resident #1 got out of the facility and believed he could have slipped out after a family member left the facility. The Administrator stated all staff were provided in-service education on abuse and neglect, elopement policy and procedure, door codes, not using exit-doors as entrance to the facility, and red box alarms. The Administrator stated QAPI will be held at the end of the month.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/20/25 beginning at 2:24 PM, CNA B stated he was giving a shower on 02/10/25 when Resident #1 escaped, and he did not see anything. CNA B said he did not hear any alarms going off or he would have attempted to investigate. CNA B stated Resident #1 normally wandered and tried to get out of the facility. CNA B stated he last saw Resident #1 when he served them snacks and orange juice at approximately 4:30 PM. CNA B stated Resident #1 had been wandering up and down the hallways prior to the incident but he did not notice any issues or problems with the doors or door alarms.</p> <p>During interviews conducted on 02/20/25 between 1:29 PM and 3:45 PM, reflected ADON L, RN A, RN D, LVN E, LVN M, MA K, MA Q, CNA B, CNA F, CNA N, CNA O, CNA R, NA G, NA H, and NA P were provided in-service education on abuse and neglect, elopement policy and procedure, not using the exit-door on the secured unit for entrance and exit, door codes and red box alarms. The staff were able to give examples of the different types of abuse to include neglect, identify the abuse coordinator, and verbalize abuse or neglect should be reported immediately. The staff were able to verbalize policy and procedure for elopement and identified residents at risk. The staff were able to verbalize interventions that could be used to prevent elopement for residents at risk. The staff stated the were not able to use the exit-doors on the secured unit for entrance or exit to the facility. The staff stated the red box door alarms should be on the on position at all times. The staff stated the door codes were changed and they were instructed to not give the code out and if family members needed to leave the staff had to let them out.</p> <p>During an interview on 02/24/25 beginning at 11:33 AM, the Maintenance Director stated the exit-doors on the secured unit were checked weekly and for any complaints or as needed. The Maintenance Director stated the red box alarm batteries were changed every month. The Maintenance Director stated on 02/10/25 when he arrived at the facility, the red box alarm was on the off position, but the keypad and door were functioning properly. The Maintenance Director stated, you could have the best system in the world but if it isn't on then it won't work. Surveyor requested documentation of door checks.</p> <p>Record review of the maintenance door check logs reflected the exit doors were checked with no issues identified on 01/03/25, 01/06/25, 01/10/25, 01/13/25, 01/20/25, 01/24/25, 01/27/25, 01/31/25, 02/03/25, 02/07/25, 02/10/25, 02/14/25, 02/17/25, and 02/21/25.</p> <p>Record review of the Wandering, Unsafe Resident policy, revised December 2007, reflected the facility will strive to prevent unsafe wandering while maintaining the least restive environment for all residents who are at risk for elopement .nursing staff will document circumstances related to unsafe actions, including wandering, by a resident .staff will institute a detailed monitoring plan, as indicated for residents who are assessed to have a high risk of elopement .</p> <p>The noncompliance was identified as PNC. The IJ began on 02/10/25 and ended on 02/10/25. The facility had corrected the noncompliance before the survey began.</p>		