

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45831</b></p> <p>Based on interviews, and record review, the facility failed to immediately notify the resident's responsible party consistent with his or her authority, when there was an accident involving the resident which results in injury and has the potential for requiring physician intervention for 1 of 4 residents (Resident #2) reviewed for notification of changes.</p> <p>LVN D failed to promptly notify Resident #2's responsible party when an injury of unknown origin was discovered on Resident #2's face during the evening on 01/18/2025. Resident #2's responsible party was not made aware of the injury of unknown origin until she arrived at the facility to visit the next day on 01/19/2025. Resident #2 was transferred back to the Hospice In-House Unit where she was diagnosed with a hematoma (collection of blood that has accumulated outside of blood vessels in a localized area).</p> <p>This deficient practice could place residents at risk of not having their responsible party informed when there was a change in condition resulting in a delay in medical intervention and decline in health.</p> <p>Findings included:</p> <p>Record review of Resident #2's undated Face Sheet revealed that the resident was an [AGE] year-old female that admitted to the facility on [DATE]. Resident #2 admitted under hospice with diagnoses including cirrhosis of the liver (scar tissue), chronic obstructive pulmonary disease (inflammation and narrowing of the airways), coronary artery disease (narrowing of the arteries), heart failure, restlessness and agitation, and personal history of other diseases of the circulatory system.</p> <p>Record review of Resident #2's Admission MDS Assessment, dated 01/11/2025, reflected Resident #2 did not meet the criteria for a Brief Interview for Mental Status (assess a person's cognitive function). Resident #2 was assessed to require assistance with ADLs including the following: eating, dressing, personal hygiene, showers, and transfers.</p> <p>Record review of Resident #2's undated Care Plan revealed she was a DNR with interventions including keep my family and MD updated on my condition.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's electronic medical records reflected Resident #2 had a progress note on 01/18/2025 at 2:24 pm that was entered by LVN D. The progress note revealed [LVN D] was called by the CNA to [Resident #2's] room regarding she had a small scratch on her right forehead. Upon entering the room [Resident #2] was in the bed, awake, alert, confused and disoriented, respirations even and unlabored, and there was no bleeding from the small area on the right forehead. The MD [Name] was notified and gave an order to monitor [Resident #2]. The family was called, left no answer. [Resident #2] was monitored, and the call light was within reach.</p> <p>Record review of Resident #2's electronic medical records reflected Resident #2 had a progress note on 01/18/2025 at 2:33 pm that was entered by LVN D. The progress note revealed. Vitals: Temperature 97.4 degrees F - 1/19/2025 02:37 pm Route: Forehead (non-contact); Blood Pressure 126/52 - 1/19/2025 02:37 pm Position: Lying left/arm; Pulse 70 - 1/19/2025 02:37 pm Pulse Type: Regular; Respiratory 18 - 1/19/2025 02:37 pm; O2 93 % - 1/19/2025 02:37 pm Method: Oxygen via Nasal Cannula.</p> <p>Record review of Resident #2's electronic medical records reflected Resident #2 had a progress note on 01/19/2025 at 2:47 pm that was entered by LVN D. The progress note revealed follow-up area on the forehead, [Resident #2's] face looked bruised and area on the forehead remained. The right side of the face was bruised with some bruises; pain medication was given this morning and lorazepam for anxiety. [Resident #2] was monitored.</p> <p>Interview on 01/24/2025 at 11:15 am with the RP, she stated Resident #2 entered hospice in July 2024 for COPD, cirrhosis of the liver and heart failure. The RP stated she was not notified on Saturday evening (01/18/2025) by LVN D when Resident #2 was observed with bruising to her face. The RP stated she noticed the bruising when she arrived to visit Resident #2 the next morning on Sunday (01/19/2025). The RP stated hospice then went to assess Resident #2 and transferred her back to the Hospice In-House Unit. The RP confirmed the DON followed up with her the next day and informed her that she believed the bruising was delayed from her fall on 01/15/2025.</p> <p>Interview on 01/27/2025 at 02:45 pm with LVN D, she stated on 01/18/2025, CNA B told her that Resident #2 had a small bruise on her forehead. LVN D stated she went to look at it, and Resident #2 was sitting up on the bed. LVN D stated there was no blood, so she completed a Skin Incident Report for Resident #2's forehead and called hospice. LVN D stated she did not notice any pronounced bruising on Resident #2's face until the next morning. LVN D stated she did not see Resident #2 fall nor observe her on the floor, she was still sitting up on the side of the bed. LVN D stated Resident #2's bruising must had set in overnight and she saw it the next morning. LVN D stated she called hospice on 01/18/2025 about Resident #2's forehead and called them that morning on 01/19/2025 about the bruising. LVN D stated she did not call the family. LVN D stated she thought hospice may relay the message to the family. LVN D stated they normally called the family. LVN D stated there was no reason she did not call the RP. LVN D stated per policy, she should had called the RP.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 01/27/2025 at 03:20 pm with Hospice RN A, she stated she was Resident #2's assigned hospice nurse. Hospice RN A stated she had no concerns for the care provided at the facility. Hospice RN A stated Resident #2 had a rapid decline and she believed she would have passed within 7 days. Hospice RN A stated when she saw Resident #2 on 01/15/2025, she was going to mark her status as being, eminent. She stated Resident #2 was always in pain and she was thinking was it restlessness from pain or more terminal restlessness, but she just was not ready to make that call that day. She stated she was going to update Resident #2's status the following week, but Resident #2 was readmitted back to their Hospice In-House Unit on 01/19/2025. Hospice RN A confirmed that hospice provided Resident #2 with a bedside table.</p> <p>Interview on 01/27/2025 at 03:40 pm with Hospice RN B, she stated she sent Resident #2 back to the Hospice In-House Unit on 01/19/2025. Hospice RN B stated Resident #2 was evaluated by the doctor and noted with a hematoma to the left side of the forehead. Hospice RN B stated there was nothing suspicious and she did not suspect foul play. Hospice RN B stated the bruising was blackish blue and could have been from the night before. Hospice RN B stated she notified the family that Resident #2 would be transferred back to Hospice In-house Unit and they agreed. Hospice RN B stated it looked as though Resident #2 may have bumped something hard. Hospice RN B stated with Resident #2's condition, she sustained injuries easily. Hospice RN B stated when she assessed Resident #2 she was resting in bed. Hospice RN B stated staff reported Resident #2 was found yesterday, 02/28/2025 sitting on the side of the bed with a small bruise to the face. Hospice RN B stated staff reported they believed Resident #2 hit her face on the overbed table while sitting up. Hospice RN B stated LVN D reported she did not believe it was from a fall and that was why she did not report a fall. Hospice RN B stated the bruising probably developed through the night. Hospice RN B stated Resident #2 had poor skin turgor and only weighed 85 lbs. Hospice RN B stated she believed Resident #2 was getting close to the end.</p> <p>Interview on 01/27/2025 at 04:15 pm with the DON, she stated Resident #2 admitted to the facility on [DATE] already on hospice and she was impulsive and very confused. The DON stated she assessed Resident #2 and you could not keep her in the bed. The DON stated they would reposition her, and she continued to move. The DON stated even Lorazepam could not control Resident #2. The DON stated the bed was kept in the lowest position and Resident #2 would crawl all over the place. The DON stated she was informed Resident #2 sustained a fall on 01/15/2025 and landed on her right side. Resident #2 said she was sorry and did not know how she fell. The DON stated they assessed her, completed neuro checks around the clock and reported it to hospice. The DON stated Resident #2 had slight bruising on the right side of her forehead, but there was no bleeding or broken skin. The DON stated hospice brought in a thick bedside table and kept it by the bed. The DON stated they would sometimes find Resident #2 lying under the table. The DON stated when Resident #2 raised up, her head would sometimes be under the table. The DON stated she believed the bruising on 01/19/2025 was delayed from Resident #2's fall on 01/15/2025. The DON stated there was even a scab on it and if it had been bruising from 01/18/2025, it would have been fresh bruising. The DON stated they were able to determine that the bruising was delayed. The DON stated they could tell that the bruising was yellow and the purple was coming in. The DON stated she, the ADON and the IDT discussed it during their morning meeting. The DON stated per policy, LVN D should have called the RP in addition to hospice.</p> <p>On 01/27/2025, multiple attempts were made to contact the MD. A returned phone call was not received prior to exiting.</p> <p>Record Review of the Change in a Resident's Condition or Status Policy dated December 2024 reflected that:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status.</p> <p>4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:</p> <p>a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;</p> <p>b. There is a significant change in the resident's physical, mental, or psychosocial status;.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45831</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure the resident received adequate supervision to prevent accidents for one (Resident #1) resident of three residents reviewed for elopement.</p> <p>The facility failed to ensure Resident #1 was adequately supervised to prevent him from leaving the facility unsupervised on 01/13/2025. Resident #1 had unspecified dementia, other lack of coordination and wore a wander guard. Resident #1 eloped from the facility without anyone noticing him or hearing the wander guard alarm system go off. Resident #1 was located between the facility's white fence and the home next door approximately 10-15 feet from the facility's nearest exit door.</p> <p>The noncompliance was identified as PNC. The IJ began on 01/13/2025 and ended on 01/13/2025. The facility had corrected the noncompliance before the survey began.</p> <p>This failure placed residents at risk for harm and/or serious injury.</p> <p>Findings included:</p> <p>Record review of Resident #1's undated Facesheet reflected Resident #1 was a [AGE] year-old-male who admitted to the facility on [DATE] and discharged on [DATE]. Resident #1 had diagnoses which included: dementia (confusion and forgetfulness), other lack of coordination (problem with balance), unspecified cataracts (clouding of the lens in your eye) and viral hepatitis (infection that causes liver inflammation and damage).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated 12/05/2024 reflected Resident #1 had a BIMs score of 3, which indicated severe cognitive impairment. Under Section E (Behavior) did not reflect any wandering behavior for Resident #1. Under Section GG (Functional Abilities) reflected Resident #1 ambulated independently.</p> <p>Record review of Resident #1's undated care plan, reflected Resident #1 was an elopement risk/wanderer with interventions/tasks that included, staff to monitor wander guard.</p> <p>Record review of Resident #1's clinical record reflected an Elopement Risk Assessment completed on 01/13/2025, indicating a high risk for elopement.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>Record review of the Provider Investigation Report dated 01/13/2025 revealed on 01/13/2025 [Resident #1] was observed sitting in the dining room eating breakfast at 8:00 am. At 08:15 am, staff were alerted that the resident was outside. [Resident #1] was noted to be found by staff on the facilities sidewalk between the facility and the adjacent home, approximately 15-20 feet from the facility's exterior door. [Resident #1] was promptly and easily re-directed back into the facility and a head-to-toe assessment followed immediately, with no injuries noted. When asked about his intentions, [Resident #1] stated, I was going to pick up some money [Resident #1] was placed on one-on-one supervision, and an elopement assessment was completed. [Resident #1] reported no pain or discomfort. The MD and Family was promptly notified. An Order was received for transfer to a male secure unit at another SNF facility. [Resident #1] remained on one-on-one supervision until time of transfer the same day at 04:00 pm. The facility investigation findings were inconclusive.</p> <p>Record review of Resident #1's Physician Orders reflected Check wander guard every shift effective 11/1/2023.</p> <p>Record review of Resident #1's order summary dated 12/01/2024 to 01/13/2025 revealed a new order starting on 01/13/2025 for 1:1 Monitoring x 24 hours every shift for 2 days.</p> <p>Review of website: timeanddate.com on 01/30/2025 reflected the following temperatures for the area the facility was located:</p> <p>1/13/24 7:53 AM 31 F</p> <p>1/13/24 8:53 AM 34 F</p> <p>Record review of Resident #1's progress notes dated 01/13/2025 at 09:33 AM written by the SW revealed, [Resident #1] recently moved to another room due to [Resident #1] and roommate not being compatible. [Resident #1's] prior roommate stated that [Resident #1] was packing up his belongings and putting them on the roommate's bed while he was in the bed. [Resident #1] had confusion and wandered about the facility and appeared to be more lost since the room move. [Resident #1] was pleasantly confused. The nurse reported that [Resident #1] exited the facility this morning. [Resident #1] will need alternate placement in a secured memory care unit. [Resident #1] was currently on one-to-one supervision at this time.</p> <p>Record review of Resident #1's progress notes dated 01/13/2025 at 11:59 AM written by the SW revealed, I called other facilities with secured areas ([Name of other Facilities]) to see if they have any openings in their secured areas. [Name of Facilities] have openings. I have sent [Resident #1] referral paperwork to [Name of Facilities] (marked urgent) and will follow up shortly. I spoke with [Resident #1] [family member]/RP. He understood and is fine with [Resident #1] moving to either of the above facilities. I will notify him once I know which facility [Resident #1] will be going to and what time. [Resident #1] remains on one-to-one supervision at this time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>Record review of Resident #1's progress notes dated 01/13/2025 at 01:25 PM written by [LVN] revealed, the resident was found walking outside of facility by another employee. [Resident #1] went out the side door of the facility after he finished breakfast. [Resident #1] stated he was trying to get his money. [Resident #1] was brought back into the facility by staff, he was redirected, and educated on the importance/safety of not exit seeking from the building. [Resident #1] was also placed on 15-minute observation, and an aide was with him at all times. [Family member] was notified of situation and understood that [Resident #1] did leave facility, and the actions the facility has taken to ensure his safety.</p> <p>Record review of Resident #1's progress notes dated 01/13/2025 at 03:54 PM written by LVN C revealed, the representative from [Facility] was at the facility to pick up the resident for admission to facility. All meds, med list with face sheet were provided and the resident was transported. The MD was notified.</p> <p>During an observation and interview on 01/24/2025 at 12:05 pm with the DON, the outside of the facility, the parking lot, both sides of the facility, the house next door, the four-lane street and surrounding area were observed by Surveyor. The facility was located in a business and residential area and was adjacent to a multi-purpose gas station on one side and a private residence on the other side. The DON reported Resident #1 was located standing in the grass area adjacent to the house next door approximately 10-15 feet from the facility's nearest exit door.</p> <p>In an interview on 01/24/2025 at 02:15 pm with the HRM, she stated when she returned to the facility on [DATE] around 08:15 am, as she walked towards the door, something caught her eye and she saw Resident #1 walking outside of the facility. The HRM stated CNA E had already ran outside and yelled that was Resident #1. The HRM stated Resident #1 stopped by the white fence that separated the facility from the home next door. The HRM stated they spoke with Resident #1 and redirected him back into the building. The HRM stated Resident #1 kept saying let me go. The HRM stated nothing they said worked. The HRM stated they eventually got Resident #1 to return to the facility as they convinced him he needed to put on a jacket. The HRM stated she was in-serviced by the DON and the MTD on elopements, wander guard and door alarms and they completed elopement drills on several days.</p> <p>In an interview on 01/24/2025 at 02:40 pm with LVN A, she stated they believed Resident #1 exited the front door when someone left out because it took 15 seconds for the alarm to re-activate. LVN A said the HRM saw Resident #1 outside and CNA E ran outside after him. LVN A stated they brought Resident #1 back inside, assessed him, and placed him on 1:1 monitoring until he transferred to a secure unit. LVN A said Resident #1 wore a wander guard and he had never eloped prior to the incident. LVN A said she took the two residents that wore a wander guard to the front door and ensured the wander guards worked properly. LVN A said she was in-serviced on abuse and neglect, elopements, wander guards, door alarms and they completed elopement drills. LVN A stated the wander guard alarm sound was now different and louder throughout the facility. LVN A said she was in-serviced by the DON and the MTD. LVN A stated she did not learn anything new, and the only thing that was different was the sound of the alarm and its increased volume.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>In an observation and interview on 01/24/2025 at 03:50 pm with the MTD, revealed the wander guard system had been checked weekly. The MTD provided a copy of the Doors, Locks, &amp; Alarms logbook and it revealed it was updated. The MTD stated they had a wander guard alarm on the 100 and 200 hall exit doors by the nurse's station. The MTD stated the main entrance, the 400 hall and the backdoor all have an alarm that released in 15 seconds. The MTD stated management requested he check the alarms weekly, but he checked the alarms three times a day. The MTD stated they had not had any issues with the alarms. The MTD stated if they had any issues, they called [Service Company]. The MTD stated no resident knew the door code. The MTD stated he checked all the exit doors and they were all operating properly. The MTD stated he still called [Service Company] to come out. The MTD stated the DON and he conducted in-services on door alarms, elopements, fire drills, abuse and neglect and they also conducted elopement drills on 01/14/2025, 01/15/2025, and 01/16/2025. The MTD demonstrated for the Surveyor at each door and both nursing stations that the alarm system worked properly.</p> <p>In an interview on 01/24/2025 at 04:20 pm with the DON, she stated only two residents remained with wander guards. The DON stated they had three nurses on duty and now utilized four nurses. The DON stated at the time of the elopement, the nurses were away from the nurse's station on dining duty and did not hear the alarm. The DON stated [Service Company] came out and adjusted the alarm volume on all doors and ensured everything worked properly. The DON stated [Service Company] increased the volume of the alarm system at the nurse's station and it was now heard throughout the facility. The DON stated they completed elopement drills and in-serviced on abuse and neglect, elopements and missing residents, and fire drills. The DON stated she was in-serviced by the DOR on the Elopement Process on Missing Residents and they toured the building and checked all doors. The DON stated the biggest thing for her was the alarm system and how crucial and important it was it worked properly. The DON stated it exposed her to what she needed to improve on and ensured staff did not become complacent. The DON stated it was bad it happened, but good due to being retrained and refreshed on the emergency codes.</p> <p>In an interview on 01/27/2025 at 10:00 am with LVN B, she stated she was told the HRM saw Resident #1 outside. LVN B stated Resident #1 wore a wander guard. LVN B stated Resident #1 was high functioning. LVN B stated Resident #1 liked to walk up to the doors but had never eloped. LVN B stated she was in-serviced on the alarm systems, how to recognize the sounds, and the protocols if a resident was missing. LVN B stated they completed an in-service on elopements and completed an elopement drill. LVN B stated she was in-serviced by the ADON, DON and the MTD. LVN B stated she learned the new sound system. LVN B stated the wander guard system had a different tone now and the volume was much louder.</p> <p>In an interview on 01/27/2025 at 10:25 am with CNA A, he stated he was informed when he exited a door to make sure the door closed properly. CNA A stated if someone eloped, he searched the inside and outside of the building and if needed, he expanded the search. CNA A stated he was in-serviced on abuse and neglect, doors and door codes, elopements, fire drills and they signed the paperwork. CNA A stated he was in-serviced by the MTD and the DON. CNA A stated the in-services were more of a re-education as he already knew the information.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>In an interview on 01/27/2025 at 10:50 am with CNA B, she stated she was at work when Resident #1 eloped. CNA B stated Resident #1 had recently moved to another hall. CNA B stated after Resident #1 finished breakfast, he walked back towards his room. CNA B stated she returned to the dining room and assisted with breakfast. CNA B stated she observed Resident #1 re-enter the facility with the HRM and CNA E. CNA B stated the ADON assigned her to 1:1 supervision and she completed a 15-minute checklist. CNA B stated she was in-serviced on abuse and neglect, elopement policy, wander guard system, 15-Minute elopement checklist, and the different emergency color codes. CNA B stated she was in-serviced by the ADON, the DON, and the MTD. CNA B stated she did not learn anything new. CNA B stated she continued to monitor all residents more closely.</p> <p>In an interview on 01/27/2025 at 01:25 pm with CNA C, she stated she was not at work when the incident occurred. CNA C stated she was in-serviced by the DON and the MTD on abuse and neglect, the different alarm systems, door codes, elopement, and what to do and how to react if one of these situations occurred. CNA C stated they completed an elopement drill and had unscheduled fire drills without warning. CNA C stated whenever she saw Resident #1 approach the door, she immediately redirected him. CNA C stated even if Resident #1 stared at the door, she redirected him. CNA C stated the in-services were more of a refresher. CNA C stated she would not do anything different, just remain aware and vigilant.</p> <p>In an interview on 01/27/2025 at 01:50 pm with CNA D, she stated Resident #1 eloped prior to her shift. CNA D stated Resident #1 stayed in his room mostly and did things for himself. CNA D stated she did not know what made Resident #1 leave. CNA D said she was in-serviced by the DON and the MTD on door alarms and if the fire alarm sounded, they called 911. CNA D said they had alarms on the doors in case a resident attempted to leave unsupervised. CNA D stated the alarms were now louder and she noticed the difference. CNA D said they were in-serviced on elopements and they completed an elopement drill. CNA D stated the MTD conducted the drills. CNA D said the DON conducted the training on abuse and neglect. CNA D stated she did not know what could had been done different. CNA D stated based on what she learned, it was a refresher and she would not be doing anything different.</p> <p>In an interview on 01/27/2025 at 02:15 pm with LVN C, he stated this incident occurred prior to his shift, but Resident #1 was transferred out during his shift. LVN C stated he was told Resident #1 exited the building and had to be redirected inside. LVN C said Resident #1 was new to his hall as he had transferred to a new room. LVN C stated he was unaware if Resident #1 ever attempted to leave the facility. LVN C stated he believed everything was handled accordingly. LVN C stated all doors had been tested . LVN C stated Resident #1 would ask him where his room was located. LVN C stated Resident #1 never came across as an exit-seeker. LVN C stated he was in-serviced on elopements, abuse and neglect, and they conducted an elopement drill. LVN C stated he was in-serviced by the ADON and the DON. LVN C stated the MTD was present and he led the actual elopement drill. LVN C stated the wander guard system is now much louder. LVN C stated he did not learn anything new and it was more of a refresher. LVN C stated moving forward, he would be more vigilant and mindful of the residents that like to wander.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>In an interview on 01/27/2025 at 02:30 pm with the MR/ADC, she stated she was at work but did not see what happened. The MR/ADC stated she sat at the main entrance and Resident #1 had not exited from her area. The MR/ADC stated she did not see Resident #1 walk past her office window. The MR/ADC stated when she heard Resident #1 got out, she searched inside and outside. The MR/ADC stated she completed a fire and elopement drill and was in-serviced on abuse and neglect, door codes, and elopement. The MR/ADC stated Resident #1 was quiet and had never eloped. The MR/ADC stated she learned to pay attention even when she was already paying attention. The MR/ADC stated moving forward, she would go outside and look to make sure no resident was out front. The MR/ADC stated the alarm system was much louder now.</p> <p>In an interview on 01/27/2025 at 02:45 pm with LVN D, she stated she was not working when Resident #1 eloped. LVN D stated Resident #1 recently transferred from her hall. LVN D stated she was in-serviced on abuse and neglect, the elopement policy, monitoring the residents, door safety, and the alarm systems. LVN D said they also conducted an all-staff elopement drill. LVN D stated if they saw a resident leaving, they were supposed to make sure the wander guard is on and working properly.</p> <p>On 01/27/2025, multiple attempts were made to contact the MD. A returned phone call was not received prior to exiting.</p> <p>On 01/27/2025, multiple attempts were made to contact the ADON. A returned phone call was not received prior to exiting.</p> <p>On 01/27/2025, multiple attempts were made to contact CNA E. A returned phone call was not received prior to exiting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>In an interview on 01/27/2025 at 04:15 pm with the DON, she stated Resident #1 recently moved to a new room. The DON stated the room change made Resident #1 confused and disoriented due to his new surroundings. The DON stated Resident #1 wore a wander guard due to aimlessly wandering throughout the facility. The DON stated Resident #1 had been in the dining room eating breakfast as usual. The DON stated once Resident #1 finished eating, he normally went back to his room. The DON stated Resident #1 was stopped between the facility and the house next door. The DON stated there had been maybe a 15-minute gap from the time Resident #1 finished breakfast. The DON stated Resident #1 had never tried to elope. The DON stated Resident #1 watched tv, slept, and minded his business. The DON stated Resident #1 was not an exit-seeking resident. The DON stated Resident #1 started wearing a wander guard in July 2023 due to wanting to return home and pushing on the door. The DON stated they kept eyes on Resident #1 and he had done good. The DON stated they explained to the family back then if Resident #1 tried to elope he would be transferred out. The DON stated Resident #1 never tried to leave until the recent incident on 01/13/2025. The DON stated Resident #1 was assessed with no injuries, placed on 1:1 and transferred out the same day. The DON stated the MTD checked the alarms every morning and at the end of the day. The DON stated on 01/13/2025 the MTD said he checked the doors and alarms at 08:00 am and they worked properly. The DON stated she could not say for sure, which door Resident #1 exited from because they found him on the side of the building. The DON stated if Resident #1 had exited the front door, the alarm was loud and the wander guard would had triggered it. The DON stated the side doors had alarms and wander guard systems were at both nursing stations. The DON stated they did not have video cameras. The DON stated staff observed Resident #1 at 08:00 am in the dining room, and they observed him again outside at approximately 8:15 am. The DON stated the alarms were checked at 08:00 am and worked properly. The DON stated the HRM saw Resident #1 outside when she returned from the store. The DON stated either Resident #1 pushed the door, or he followed someone out. The DON stated due to it being breakfast time, no one was at either nurse's station. The DON stated the nurses went to the dining room to assist. The DON stated the CNAs assisted in the dining room after passing trays on the halls.</p> <p>Record review of the Quality Assurance Performance Improvement Meeting revealed it was held on 01/20/2025 with the Medical Director in attendance. Under Nursing Concerns, QM Action Plan or PIP reflected, Elopement Incident regarding Resident #1 with interventions put in place.</p> <p>Elopement - Dated 01/13/2025</p> <p>A new elopement assessment was conducted on 01/13/2025 to identify any residents who may be at imminent risk of elopement. No residents were found to be at immediate risk.</p> <p>Responsibility: Nurse Management</p> <p>Monitoring: Regional Director of Clinical Services / Director of Nursing</p> <p>Elopement assessments will be completed upon admission, on a quarterly basis, and whenever a resident triggers a potential imminent risk for elopement. In such cases, the elopement response protocol will be activated.</p> <p>Any resident identified as having an elopement risk will be placed under 1:1 monitoring until it is no longer deemed necessary.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>Monitoring: Regional Director of Clinical Services - Residents at risk of elopement will remain on 1:1 supervision until alternative or safe living arrangements are found. They will be supervised by facility staff.</p> <p>The resident's photo and face sheet will be included in an elopement binder, and care plans will be updated accordingly.</p> <p>The Director of Nursing and/or Nurse Manager will conduct weekly audits to ensure compliance by reviewing elopement assessments and the elopement binders.</p> <p>These audits will be performed weekly for a duration of four weeks, ending on 02/06/2024, and will then be conducted monthly on an ongoing basis.</p> <p>The Regional Director of Clinical Services will also review the documentation weekly for compliance.</p> <p>The Executive Director will monitor daily compliance for the first four weeks, then conduct a review.</p> <p>Record review of an in-service dated 01/13/2025 reflected all staff attended and the subject matter was regarding the facility policy on Missing Resident Drill: Create an incident response protocol that staff can easily activate when a patient is missing. The protocol should specify the sequence of events (e.g., the action plan) that should take place when staff are notified that a patient is missing. The protocol should include the communication plan (e.g., notification of unit supervisor, security, patient's physician, patient's family, administration) and must include up-to-date contact information for all parties who need to be notified. Ensure that all staff are educated about preventing and responding to elopement events e.g., risk factors, communication protocols, action plans). Evaluate elopement events and attempted elopement events to identify gaps in the protocol or in staff education or response. Modify the protocol as needed.</p> <p>Record review of the Elopement Drill Checklists for an all-staff elopement drill revealed drills were conducted on 01/14/2025 at 10:00 am, 01/15/2025 at 10:00 pm, and 01/16/2025 at 01:30 pm.</p> <p>Record review of an in-service dated 01/14/2025 reflected all staff attended and the subject matter was regarding the facility policy on abuse and neglect.</p> <p>Record review of an invoice from [Company] dated 01/13/2025 revealed under notes, Checked all doors and all mag locks are locked and alarming and egressing as they should.</p> <p>Interviews were conducted with facility staff from various shifts on 01/27/2025 from 3:00 pm to 4:00 pm. Staff interviewed were ADON, HRM, CNA A, CNA B, CNA C, CNA D, LVN A, LVN B, LVN C, LVN D.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675806	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2025
NAME OF PROVIDER OR SUPPLIER  The Laurenwood Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  330 W Camp Wisdom Rd Duncanville, TX 75116	
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>Interviews with staff revealed they verbalized comprehension of the in-service training. They stated they had been in-serviced on responding to all alarms to ensure resident safety, how to check the panel on the halls to determine what door alarm was sounding, conducting a resident head count, full searches inside/outside the facility, and ensuring they searched all sides of the building outside.</p> <p>Record review of the Facility's Policy titled Elopements revised December 2024 reflected:</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing .2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the departure in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the Charge Nurse or the Director of Nursing Services that a resident has left the premises. 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall; a. examine the resident; b. Notify the attending physician; c. Notify the resident's legal representative (sponsor) of the incident; d. Complete and file Report of Incident/Accident; and e. Document the event in the resident's medical record.</p>		