

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676291	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Oakcrest Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9808 Crofford LN Austin, TX 78724	

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** 45070</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistant device to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accident hazards/supervision.</p> <p>Resident #1 walked out of the facility unattended on 04/01/24 at 8:08PM and remained missing as on 04/10/24 at 3:00PM. LVN B failed to physically check during the two-hour monitoring to ensure Resident #1 was in the building during and after his elopement.</p> <p>An IJ was identified on 04/03/24 at 5:00PM. The IJ template was provided to the facility on [DATE] at 6:00PM. While the IJ was removed on 04/05/24 at 9:12AM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm but potential for harm as the resident was missing as on 04/10/24.</p> <p>This failure could affect residents and place them at risk of not receiving the appropriate level of supervision to prevent physical harm, pain and accidents.</p> <p>Findings Included:</p> <p>Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included Schizoaffective Disorder (a type of mental illness), Repeated Falls, Muscle weakness, Disorder of Kidney and Ureter and Hypertension (High blood pressure).</p> <p>Record review of Resident #1's MDS dated [DATE] revealed a BIMS Score of 13 indicating Resident #1 was cognitively intact.</p> <p>Record review of Resident #1's care plan dated 01/18/2024 revealed Resident #1 had the habit of intruding into other resident's privacy and the intervention was placing Resident #1 in area where frequent observation was possible.</p> <p>Record review of Resident #1's Elopement Risk Evaluation dated 01/18/24 reflected a score of 7 indicating Resident #1 was at no risk for elopement.</p> <p>Record review on 04/03/24 of Resident #1's medication order revealed resident was on the following medications:</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>Clozapine Immediate Release 200MG daily at bedtime</p> <p>Clozapine 100MG tablet in the morning</p> <p>Haloperidol 5mg at night</p> <p>Haloperidol 5mg at noon</p> <p>Donepezil HCL 10MG daily</p> <p>Trazadone 25MG at night</p> <p>Simvastatin 5MG every night</p> <p>Gemfimbrosil 600MG twice a day</p> <p>Metoprolol Tartrate 37.5MG Twice a day</p> <p>Record review on 04/03/24 of Resident #1's MAR for the month of April revealed that on 04/01/24 all his medications scheduled for 9:00PM, were administered by CNA D.</p> <p>Record review of facility's incident report to HHSC dated 04/02/24 reflected, on 04/02/24 at 7:30AM staff noticed Resident #1 was missing and not on the property. CC camera review showed Resident #1 eloped from facility through a secured exit gate on 04/01/24 at 8:08PM.</p> <p>Record review on 04/03/24 of Facility's Monitoring Sheet Every Two Hours' dated 04/01/24, documented by LVN B, reflected resident was at the facility at 5PM,7PM,9PM,11PM,1AM,3AM and 5AM and Monitoring Sheet Every Two Hours' dated 04/02/24 reflected Resident #1 was absent at the facility since 7AM.</p> <p>Observation on 04/03/24 at 11.45AM of the CC camera footage revealed Resident #1 exited through one of the facility's three locked fence gates around the facility on 04/01/24 at 8:08PM by opening forcefully.</p> <p>Observation of Resident #1's room on 04/03/24 at 11:00AM revealed he was sharing the room with another resident. Resident #1's bed was towards the window, away from the door. His privacy curtain was fully drawn so that his bed was not visible from the door.</p> <p>During an interview on 04/03/24 at 11:30 AM, LVN A stated she knew Resident #1 very well since his admission a few years ago. She said on 04/01/24 she did overtime and left the facility at about 7:30PM. LVN A stated Resident #1 was in the facility at around 7:00PM and she marked his presence on the two hour's monitoring sheet. LVN A stated she came to know Resident #1's elopement on 04/02/24 at about 8:00AM when she arrived for work and observed staff and police were on the lookout for Resident #1.</p> <p>During an interview on 04/03/24 at 2:30PM CNA D stated he is a Med Aide and works the afternoon shifts. He stated he had administered Resident #1's evening medications at 8:00PM on 04/01/24. CNA D said Resident #1 did not voice any concerns at that time and was appeared in his usual presentation.</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 a telephone interview on 04/03/24 at 6:00PM, LVN B stated she was the night nurse at the facility. She said she started her shift at 8:00PM on 04/01/24 and finished at 7:00AM on 04/02/24. LVN B stated she had the task of checking on residents every two hours and marked Resident #1 on the 'Two Hour's Monitoring Sheet' as present at the facility in the whole night, without physically seeing him. LVN B said she assumed Resident #1 would be at the facility since he was one of the residents with very low elopement risk, over the years. She stated to ensure the residents were present at the facility, she should have observed all of them physically at every two hours instead of assuming.</p> <p>During an interview on 04/04/24 at 7:00AM, LVN C stated she was the night nurse at the facility. She stated she worked on 04/01/24 in the East Hall where Resident #1 was not living. LVN C stated, in the nights she physically checked all the residents every two hours by entering in their rooms unlike, as observed, LVN B who used flashlight from the door for observation, without entering their rooms.</p> <p>During a telephone interview on 04/03/24 at 3:00PM the NP at the facility stated since Resident #1 had eloped, there was risk of relapsing his mental illness due to the lack of medication. She stated this would make him more vulnerable in the community and could be a threat to the safety of his and/or of the community. NP stated Resident #1 has long history of mental illness and even if he returned to the facility after few days, it would take some time to build up a therapeutic level of medications in the blood to make him mentally stable.</p> <p>During a telephone interview on 04/08/24 at 10:35AM the LEO stated Resident #1 was still missing. He stated the department was on a [NAME] to trace him down and the facility also was making efforts to find him. LEO stated he was one of the three officers who responded to the 911 call from the facility on 04/02/24 at about 7:30AM. He said the observation of the CC camera footage revealed the resident exited the facility by breaking open the gate forcefully. LEO stated, while he could not find any remarkable noncompliance of the facility, the Two Hour's Check Sheet did not make any senses as Resident #1 was marked in it as present at the facility throughout the night on 04/01/24. He said, it was clear from the CC camera footage that he exited the facility at about 8:00PM. LEO stated the earlier the search for a missing person the higher the chances of success in finding them.</p> <p>During an interview on 04/03/24 at 5:00PM the DON stated, he came to know about the elopement of the resident from a phone call by the staff on 04/02/24 at about 8:00AM, on his way to work. He stated Resident #1 was on low risk of elopement and on 2 hours observation whereas a resident with high risk of elopement were on 30minutes check. The DON stated staff who do the checks should make sure that they physically observed the resident before signing off the monitoring sheet in order to eliminate issues like elopement. The DON stated there was no system at the facility in place to check the accuracy of these observations.</p> <p>During an interview on 04/03/24 at 5:30PM the ADM stated the facility had no right to stop Resident #1 from leaving the facility as he was the responsible party for himself. When the investigator asked ADM if Resident #1 discussed with him or staff about leaving the facility and signed or refused to sign any documents like AMA, ADM stated Resident #1 did not do so any time before eloping. the ADM also stated Resident #1 had not taken any medication with him as well, as all his medications were stored and managed by the facility.</p> <p>Review of facility policy 2 hr Resident Monitoring dated 09/10/2016 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 - Few</p>	<p>Policy: Resident who score 0-8 on the Elopement /Wandering Risk Assessment will be checked physically present Q2 hours.</p> <ol style="list-style-type: none"> 1.Nursing staff will conduct rounds Q 2 hours on their assigned residents. 2.Nursing staff will use assigned 2 hrs monitoring checklist to document their checks. 3.Nursing staff must confirm time checked and initial checklist. 4.Nursing staff must report any resident that is not accounted for during their checks immediately to their supervisor in order to initiate a possible elopement protocol. 5.If an elopement protocol is initiated, the nurse supervisor must contact the Administrator and DON immediately for assistance. <p>Indicate that a plan of removal was requested; when it was received and accepted.</p> <p>The notification of Immediate Jeopardy states as follows:</p> <p>The facility failed to ensure all the residents were present in the facility by doing routine checks accurately, resulted in the elopement of Resident #1 unnoticed</p> <p>Action:</p> <p>All residents were re-assessed for elopement risk with no new residents identified on 4/02/2024. All Nursing Staff Inservice to include PRN and New Hires on doing routine checks accurately to ensure residents are in facility and accounted for as per our 2-hour monitoring checklist. (No Agency in Use). Per checklist, Residents who score 0-8 on the Elopement/Wandering risk Assessment must be checked physically present by setting eyes on resident to ensure present Q 2 hours.</p> <p>Inservice of all nursing staff to ensure the 2 hr monitoring checks are being completed and that staff must set eyes on resident to ensure they are physically present, as per updated policy.</p> <p>All new admissions will continue to be assessed for elopement risk per policy.</p> <p>Start Date: 4/02/2024.</p> <p>Completion Date: 4/04/2024</p> <p>Responsible: DON</p> <p>Action:</p> <p>The charge nurse for the given shift will be the primary monitor and will ensure staff are completing checks by monitoring and signing-off on the checklist for their assigned shift. The DON will monitor the 2-hour checks for compliance through QAPI checks weekly. Administrator will be secondary QAPI monitor as needed. The DON is responsible for the training of staff. The DON has been inserviced by Regional Nurse Consultant on 4/03/2024. Administrator has been trained by DON 4/04/2024.</p> <p>(continued on next page)</p>

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