

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Epic Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3210 W Hwy 22 Corsicana, TX 75110	

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> 45957</p> <p>Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for 2 of 8 residents (Resident #1 and Resident #2) reviewed for accidents and hazards.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility on [DATE].</p> <p>The facility failed to ensure Resident #2 did not elope from the facility [DATE].</p> <p>An Immediate Jeopardy (IJ) existed from [DATE] - [DATE]. The IJ was determined to be at past noncompliance as the facility had implemented actions that corrected the deficient practice prior to the beginning of the investigation.</p> <p>This deficient practice placed residents at risk for falls, injuries, dehydration, and hospitalization .</p> <p>Findings included:</p> <p>Record review of Resident #1's admission recorded dated [DATE] documented a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had diagnoses included: unspecified dementia (loss of memory, language, problem solving and other thinking abilities), mild protein-calorie malnutrition (protein intake that is insufficient to meet bodily demands for protein synthesis and tissue repair) and muscle weakness (lack of physical or muscle strength).</p> <p>Record review of Resident #1's Quarterly MDS assessment, dated [DATE], revealed the resident had a BIMS score of 06 indicating the resident had severe cognitive impairment.</p> <p>Record review of Resident #1's care plan, dated [DATE], revealed Resident #1 was care planned for neurocognitive disorder with Lewy bodies, risk for injury from wandering in an unsafe environment, cognitive loss/dementia, and falls.</p> <p>Review of Resident #1's nursing progress note dated [DATE], reflected resident told staff he wanted the manager to know he was not eating anything anymore and he hated living here.</p> <p>Review of an Elopement Risk Assessment date [DATE], reflected Resident #1 was a risk for elopement.</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>No interview could be conducted with Resident #1 due to the Resident #1 being discharged to the VA hospital for behavioral support and elopement risks.</p> <p>Record review of Resident #2's admission recorded dated [DATE] documented a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses included: vascular dementia (chronic condition that affects the brain's ability to function by damaging blood vessels and reducing blood flow and oxygen supply), memory deficit (issue with forming, storing, or recalling memories), and anxiety (feeling of fear, dread, and uneasiness that can be a normal reaction of stress).</p> <p>Record review of Resident #2's Quarterly MDS assessment, dated [DATE], revealed the resident had a BIMS score of 05 indicating the resident had severe cognitive impairment.</p> <p>Record review of Resident #2's care plan, dated [DATE], revealed Resident #2 was care planned for episodes of anxiety, psychotropic drug use, dehydration/fluid maintenance, communication, visual function, cognitive loss/dementia, delirium, and elopement.</p> <p>Review of Resident #2's nursing progress note dated [DATE], reflected spoke Resident #2's and she said his worked at the hospital and that is probably why he went over there.</p> <p>Review of an Elopement Risk assessment dated [DATE], reflected Resident #2 was a risk for elopement.</p> <p>During an interview with Resident #2 on [DATE] at 12:45pm, Resident #2 stated that he climbed over the fence with the chairs. Resident #2 did not state why he eloped but stated he felt safe and was ok.</p> <p>An interview with RN A on [DATE] at 10:00am, revealed RN A stated Resident #2 was outside in the courtyard a few minutes before smoke time. RN A stated that Resident #2 liked to go sit in the gazebo. RN A stated that Resident #2 was only outside for about ,d+[DATE] minutes. RN A stated that she was giving resident on the secure unit fluids when LVN A brought Resident #2 back in the secure unit and stated that he was found in the hospital parking lot across the street by a prn facility staff. RN A stated that Resident #2 did not let her assess lower body but only his upper body. RN A stated Resident #2 did not have any injuries from the elopement. RN A stated that since the incident no resident was allowed in the courtyard alone. RN A stated that Resident #2 was placed on 15-minute check. RN A stated when resident was allowed in the courtyard alone staff checked on the resident every ,d+[DATE] minutes while outside. RN A stated round inside the secure unit were done at least every two hours. RN A stated that Resident #2 could have been hit by a car, died from heat exhaustion, been injured or been abducted due to his elopement.</p> <p>An interview with the CNA A on [DATE] at 12:55pm, revealed she was an agency staff, and she was in-serviced on the visual check log, missing person policy, rounds and supervision. CNA A stated no resident can be left alone in the courtyard, elopement drill will be performed twice a week for the next five weeks, window alarms were installed on the windows in the secure unit, and window and window alarms checks will be done twice a week for the next five weeks.</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>An interview with the DON on [DATE] at 1:55pm, revealed the DON stated that the facility in-serviced facility staff as well as agency staff on the visual check log, missing person policy, rounds and supervision. DON stated no resident could be left alone in the courtyard, elopement drill will be performed twice a week for the next five weeks, window alarms were installed on the windows in the secure unit, and window and window alarms check will be done twice a week for the next five weeks. DON stated that both Resident #1 and Resident #2 two used objects to get over the fence around the secure unit. DON stated that both residents could have been hit by cars, passed out, or gotten injured during the elopement incidents.</p> <p>An interview with ADM on [DATE] at 4:10pm, revealed that ADM stated in-services were done on visual check log, missing person policy, rounds, and supervision. ADM stated facility staff and agency were in-serviced on those topics of concern. ADM stated no resident can be left alone in the courtyard, elopement drill will be performed twice a week for the next five weeks, window alarms were installed on the windows in the secure unit, and window and window alarms check would be done twice a week for the next five weeks. ADM stated that both Resident #1 and Resident #2 two used objects to get over the fence around the secure unit. ADM stated that both residents could have been dehydrated, picked up by a stranger, fallen and gotten injured or hit by a car due to the elopement incidents. ADM stated she expected for staff to follow through with the invention put in place to ensure all residents were present and safe.</p> <p>Review of the facility's Safety and Supervision of Resident policy, dated 2001, revealed Our facility strives to make the environment as free from accident hazards as possible, Resident safety and supervision and assistance to prevent accidents are facility wide priorities.</p> <p>Policy Interpretation and Implementation</p> <p>Facility Oriented Approach to Safety</p> <p>1. Our facility-oriented approach to safety addresses risks for groups of residents.</p> <p>Resident Risks and Environmental Hazards</p> <p>1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:</p> <p>e. unsafe wandering .</p> <p>This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. The facility took the following actions to correct the non-compliance:</p> <p>- A Wandering/Elopement Assessment was conducted on all residents.</p> <p>- Resident #1 received 1:1 supervision until he was discharged to the VA hospital on [DATE].</p> <p>- Observation on [DATE] at 12:45pm of window alarms were installed to all windows and were working properly on the secure 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>	<ul style="list-style-type: none"> <li>- On [DATE] Resident #1 was sent to the VA Hospital for elopement risk and behavioral support.</li> <li>- All staff were in-serviced on their Missing Person Policy, Rounds, and 1:1 supervision.</li> <li>- On [DATE] at 2:55pm reviewed Elopement Drills were conducted ([DATE] and [DATE]). Elopement drills are being conducted twice a week for the next five weeks.</li> <li>- On [DATE] reviewed the facility head count sheet. The facility was conducting a head count on all residents daily.</li> <li>- Visual check logs were being completed on residents in secure unit by the Nurse at the being of each shift and turned in to the DON daily.</li> <li>- On [DATE] at 3:00pm reviewed the window and window alarm checklist. The window and window alarm checks were being conducted five times a week (conducted by maintenance and weekend supervisor)</li> <li>- Resident #2 received 15-minute supervision checks implemented on [DATE]. The 15-minute checks were completed for 72 hours. Observed the 15-minute checks documentation on [DATE] at 11:15am.</li> <li>- Both Resident #1 and Resident #2 care planned were updated with elopement risk interventions.</li> <li>- Resident #1 and Resident #2 received nursing assessments no injuries noted from elopements.</li> </ul> <p>Resident #2 was seen by the NP, no med changes and had a follow up visit in two weeks.</p> <ul style="list-style-type: none"> <li>- On [DATE] QAPI meeting was conducted.</li> <li>- The facility and VA hospital will coordinate a safe placement for Resident #1.</li> </ul>		