STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676335	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City of Ennis Dba Broadmoor Medical Lodge	5242 Medical Drive Rockwall, TX 75032

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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record reviews, the facility failed to ensure that the resident environment remained as free of accident hazards as possible for 1 of 18 Residents (Resident #37) reviewed for accidents and hazards. The facility failed to ensure Resident #37 had on her wander guard bracelet on 12/2/24 and 12/3/24. This failure could place residents at risk of elopement, injury, or harm. Findings included: 1.Record review of Resident #37's face sheet, dated 12/04/24 indicated he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory), Schizophrenia (a chronic mental disorder that affects a person's ability to think, perceive reality, and interact with others), and depression (sadness). Record review of Resident #37's quarterly MDS assessment, dated 11/21/24, indicated Resident #37 understood and was understood by others. Resident #37's BIMS score was a 10 indicating her cognition was moderately impaired. The MDS indicated Resident #37 required limited assistance with her ADLs including transfers and bed mobility. The MDS indicated she had an elopement/wander alarm. Record review of Resident #37's comprehensive care plan dated 09/30/24 indicated, she was at risk for elopement/wandering related to impaired safety awareness. The interventions were for staff to monitor the wander guard to the left lower leg and distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books. Also, remind the resident not to leave the facility without assistance. Record review of Resident 37's Physician order dated 09/16/24 indicated, she had a wander guard to the Left lower leg related to exit-seeking behaviors. Check placement every shift. Record review of Resident #37's Elopement Risk Evaluation dated 09/16/24 indicated she was at risk of elopement. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/02/24 at 11:35 a.m., Resident #37 was in bed with no wander guard bracelet on her left lower leg. During an interview on 12/04/24 at 5:00 p.m., Resident #37 said she did have on her wander guard, but it had been removed a long time ago (unknown date). During an observation and interview on 12/04/24 at 5:18 p.m., Resident #37 was lying in her bed and no wander guard was on her leg. CNA R verified by looking at Resident #37's leg and said she did not have a wander guard bracelet on. During an interview on 12/05/24 at 11:49 a.m., the DON said Resident #37 was supposed to have her wander guard on and the nurses should check for placement each shift. She said Resident #37 had removed her wander guard before but was not sure why Resident #37's wander guard was not in place. She said all staff was responsible for ensuring the residents who had orders for wander guards, had the wander guards on. She said if Resident #37 did not have on her wander guard she was at risk for elopement. During an interview on 12/05/24 at 12:46 p.m., the Administrator said if Resident #37 had an order for a wander guard, then she should have had on her wander guard. He said wander guards were used for residents at risk of wandering. He said all staff were responsible for ensuring the wander guard was in place. Record review of facility policy titled, Wandering and Elopement, dated November 15, 2023, indicated, Policy statement: The facility will identify residents who are at risk of unsafe wandering and implement appropriate protective measures to help guard against a resident wandering from the facility. The facility strives to prevent harm while maintaining the least restrictive environment for residents. Policy interpretation and implementation: identifying residents at risk 1. on admission, readmission, quarterly doing observation period of the MDSs, annual significant changes, and as needed. The nurse will screen each resident for elopement risk using the elopement risk evaluation or equivalent form. After reviewing this information, the nursing staff will determine if the resident is at risk of wandering or elopement.