STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676395	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Healthcare Resort of Plano	3325 West Plano Parkway Plano, TX 75075

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 - Immediate jeopardy to resident health or safety 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** 47030 Based on interview and record review, the facility failed to provide adequate supervision to prevent accidents, for one Resident (Resident #1) of one resident reviewed for elopement risk. The facility staff failed to ensure that a contractor working in the facility did not let Resident #1 exit out of the facility, through a side door, unsupervised on 05/24/24. After exiting, Resident #1 was found unsupervised across a major roadway by facility staff. The noncompliance was identified as PNC. The IJ began on 05/24/24 and ended on 05/31/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for serious injuries. The findings were: Record review of Resident #1's Admission Record, dated 09/10/24, revealed Resident#1 was admitted to the facility on [DATE]. Resident #1's diagnoses included Traumatic subdural hemorrhage with loss of consciousness (a type of bleeding in which a collection of blood-usually but not always associated with a traumatic brain injury-gathers between the inner layer closest to the brain tissue, the three membranes that envelop the brain and spinal cord.) and Traumatic subarachnoid hemorrhage with loss of consciousness-bleeding in the space between the brain and surrounding membrane. Record review of Resident #1's, 3 Elopement/Wandering Evaluations, dated 05/10/24, revealed Resident #1 scored 9 (low risk) for elopement/wandering. Elopement/Wandering Evaluations dated 05/11/24, revealed Resident #1 scored 21 (High risk) for elopement/wandering, dated 05/12/24, revealed Resident #1 scored 12 (High risk) for elopement/wandering. Scale-Low Risk= 0-9 High Risk=10-55. Record review of Resident #1's Progress Notes revealed documentation of Resident #1 having elopement/wandering behaviors for the month of May 2024. 05/16/24 14:24 [2:24 PM] entered by LVN G reflected Symptoms or signs noted of Condition change: Other change in condition Behavioral symptoms (e.g., agitation, psychosis) seeking exit/elopement risk (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	05/19/24 13:28 [1:28 PM] entered by RN F reflected Patient remains restless, wheeling all over building talking to everyone. Trying to wheel self around while IV fluids infusing. Instructed patient that she needed to stay close to room, so she does not pull out IV. She is confused and frustrated. Refused to speak to family member that called to check on her. 05/24/24 17:25 [5:25 PM] entered by LPN G reflected Pt was showing increasing signs of elopement risk, pt was actively seeking exit, despite multiple time of reorientation. Pt was becoming increasing aggravated and showing sign of delusional thinking. Pt was having unorganized belligerent speech. After multiple attempts made by pt to leave facility, DON [Name] and building staff were made aware of pts actions. After hearing door alarm going off in hallway, this nurse made his way to look for pt, after searching for 3 minutes this nurse notified all build staff and DON [Name] of pts absence. Multiple staff currently searching for pt. Social worker [Name] made aware and called daughter/police . 05/24/24 17:45 [5:45 PM] entered by the Social Worker reflected spoke with dispatcher- [Name] alert police of [Resident #1] not in facility. Spoke with daughter [Name] & informed her [Resident #1] left the facility & staff & police are searching for her. 05/24/24 18:45 [6:45 PM] entered by LVN G reflected :Pt was found of staff down the road from the facility, pt was picked up and brought back to the facility, pt now has sitter, family showed up .Pts skin assess with no new issued, VS assessed and all were stable .Pt stated they feel fine, pain addressed, pt states she had no at all Pt was taken out of facility by family in person vehicle, will notify DON [Name] and other staff Record review of Resident #1's Care Plan undated due to discharge and care plan cancelled at time of investigation revealed Resident #1 was at risk for impaired cognitive function/dementia or impaired thought processes related to history of fall with subdural hematoma- a collection of blood on your brain's surfaces under the skull. -Intervention: Needs supervision/assistance with all decision making. Provide simple one-step instructions. Engage in simple, structured activities. Keep routine consistent. Record review of Resident #1's Care Plan undated due to discharged and care plan cancelled at time of investigation revealed Elopement risk/wanderer r/t Disorientation to place, Resident tends to wander around the building without an intention to go anywhere, may at times interfere with activities. -Intervention: Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes Record review of the facility's, Provider Investigation Report, dated 5/24/24, revealed: -Incident Category: Elopement -Capacity to make informed decisions: Yes -if applicable, describe any special supervision required. This area was left blank. -Known history of: Wandering: No (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Description of the Allegation: Vendor conducting air conditioning work inadvertently opened a side door to leave the facility, without notifying the staff. Staff initiated code purple. Resident was found 200ft from premises and returned to the facility. -Description of Injury: Head to toe assessment performed resulting in stable vital signs, no skin issues observed, no pain found. Resident was alert and orientated. -Provider Response: Elopement code called. Head count performed; all other residents accounted for. Staff conducted internal and external search. Family, physician, and police were notified. Family continued with discharge of the resident. In-services on Elopement/Wandering, Emergency Codes, and Abuse, Neglect, and Exploitation started. Vendor that held the door open for the resident was spoken to by the facility. -Agency Action Post-Investigation: Educated the vendor on consulting staff before allowing persons to exit building, while working in the facility. Elopement drill performed on 5/31/24 and would be performed monthly for the next 3 months. Quality improvement plan with new guidelines for vendors- Department heads were assigned vendors that were related to their department while the vendor was in the facility. - Statement from Vendor reflected I was working on the AC near the side door in the Dining Room. A few women were visiting together. I was going outside of the dining room door. One of the women approached the door and a sked if I could let her outside. I agree. I used my badge to let her out the door, trying to be helpful. Review of the weather in [NAME], TX on 05/24/24 around 4:53 PM to 5:53 PM revealed the weather ranged from 88-86-degree Fahrenheit. Review of google maps, accessed on 09/24/24, revealed that the only road that surrounded the facility was in the front. The road consisted of 3 lanes that went east, a large, landscaped median and 3 lanes that headed west. In an interview 9/10/24 at 11:53am Aide A revealed to help prevent elopement she does her routine every 2-hour room checks. If a resident that normally would be in their room is not in their room, she would check with the nurse to see if the resident is at an appointment, check to see if the resident is with therapy, re-check the resident's room. If the resident still cannot be found she would tell nurse, nurse reports to DON and do full facility internal check then external facility check and call 911. Aide A revealed the side doors have the bar that is pushed for 15 seconds and alarmed. In an interview on 9/10/24 at 1:10pm LVN A revealed there was one lady resident-Resident #1 that was out of the building and was across the street. LVN A revealed she checked the building and then went to the car dealership next door, but the resident was not there. LVN A revealed the staff are to know where the residents are always. LVN A revealed the last in-service on elopement was within the last 30 days, covering the steps and procedures of elopement. LVN A said for elopements a cold Purple is called, check the interior of the facility, do head count, call 911, check the exterior of the facility. LVN A revealed after the last elopement management posted signs at the doors warning not let people in/out the doors. This surveyor observed signs at the doors stating do not let anyone in or out of the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 9/10/24 at 1:31pm Prior Maintenance staff revealed the facility did an elopement drill and began planning other things to implement such as restrict door cards from vendors-now had to check-in, in-services and they updated QAPI to avoid elopements in the future, In an interview on 9/10/2024 at 1:55pm with DON revealed the resident that eloped was found across the street in the parking lot and she was gone a total of 15-20 minutes from when a male nurse noticed her missing from the dining room to when she was found. DON revealed the resident went out of the side door by the dining room. DON revealed an air conditioning vendor held the door open for the resident. After the elopement incident the DON said the following were put in place- accounting for vendors with sign in/out with the manager of the department, signs at the doors stating to not let people in/out, staff trained and in-serviced, receptionist available M-F until 8pm and on Saturday and Sundays. If a receptionist steps away a manager covers. The front door is alarmed to go in/out. Wanderguard-a wireless wander management system that consists of a door controller and a wearable pendant/bracelet are not used by this facility. The DON revealed the resident had no history of elopement. DON revealed the resident admitted with a brain injury. DON revealed the resident was due to discharge the same day. She was scheduled to go to a memory care facility. DON revealed the resident had verbalized she wanted to go home, and at night sometimes had sundown with agitation. DON revealed the resident eloped prior in the day to when her sundown behaviors begin. DON revealed the resident was admitted from a hospital. DON revealed the resident was care planned for elopement due to elopement assessment initially. She was re-assessed. DON revealed the resident spent most of her time at nurses' station. DON revealed the resident did most activities. DON revealed she reached out to family and discussed possible sitter services due to not discharging as planned to another facility because a bed did not become available. DON revealed the family discharged Resident #1 home with them until an opening at the new facility. DON revealed the facility had one other elopement prior to this when the DON was on vacation- and only at the facility as a temporary DON. When asked the DON revealed there have been no other elopement after this occurrence. DON revealed the facility has put more things in place to choose residents who are not elopement risks. DON revealed she felt like the facility did everything they had in place per their policy. DON revealed nurses were keeping an eye on the resident. DON revealed they did all they could with difficult family and difficulty discharge. The DON revealed since the elopement they have done several thing including: update binders that have list of at-risk of elopement resident info, educate staff, monitor all exits, do not let anyone in/out signs on doors. Monitor vendors. Binders and signs were observed. In-services were reviewed. Record review of the facility's Elopement Procedure, originally dated 6/2018 and updated 1/2022, revealed: -Policy: It is the policy of this facility to provide a safe environment for all residents through appropriate assessments and interventions to prevent accidents related to unsafe wandering or elopement. -Elopement defined- occurs when a resident leaves the facility premises or a safe area without authorization (i.e., an order for discharge, appointment, or leave of absence) and/or any necessary supervision to do so. This noncompliance was identified as Past Noncompliance (PNC). The noncompliance began on 5/24/24 and ended 5/31/24. The facility had corrected the noncompliance before the investigation began. The facility took the following actions to correct the non-compliance: (continued on next page)

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