

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2024
NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 19279 McKay Dr. Humble, TX 77338	
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** 37059 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 10 residents (Residents #1) reviewed for adequate supervision. The facility failed to provide Resident #1 with adequate supervision and monitoring related to his wandering behaviors which resulted in an elopement to an apartment complex by EMS. Resident #1 was absent from the facility for approximately 7 hours before he was noticed by staff that he was missing. This failure could affect residents who and place them at risk for physical harm and or pain. An Immediate Jeopardy (IJ) was identified on 3/28/2024. The IJ template was provided to the Administrator and DON on 3/28/2024 at 5:12 PM While the IJ was removed on 3/29/2024 at 1:45 PM, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need evaluate the effectiveness of the corrective systems. These failures could place residents at risk for possible serious injuries, harm and death to residents who require supervision. Findings include: Record review of Resident #1's face sheet, dated 3/27/2024, revealed a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses which included Dementia (loss of cognitive functioning - thinking, remembering, and reasoning), abnormalities of gait and mobility, cognitive communication deficit. Record review of Resident #1's H/P dated 3/31/2023 revealed the following in part: .He (Resident #1) ran away from the home .and family member is afraid that he (Resident #1) will escape. Record review of Resident #1's care plan dated 10/4/2023 revealed the following in part: (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Problem - Exhibits risk factors for elopement risk. Goal - will not have any episodes of elopement over the next 90 days. Approach - 1. Assess resident for increased confusion, s/s of possible elopement as needed. 2. Convey an attitude of acceptance toward the resident. 3. Document about situation and complete elopement risk assessment with any increase in s/s of possible elopement risk, report such episodes to physician as needed. Record review of Resident #1's care plan dated 3/21/2024 revealed the following in part: Problem start date: 3/21/2024 - Resident #1 experienced an elopement r/t Dementia and confusion. Long Term Goal Target Date 6/21/2024 -Resident will not have any unaddressed episodes of elopement over the next 90 days. Approach: 1. Assess resident for increased confusion, s/s of possible elopement as needed. 2. Document about situation and complete elopement risk assessment with any increase in s/s of possible elopement risk, report such episodes to the physician as needed. 3. Elopement assessment completed. 4. Medication review. 5. Social service to review, refer out to secure unit as necessary. Problem - Exhibits risk factors for elopement risk. Goal - will not have any episodes of elopement over the next 90 days. Approach - 1. Assess resident for increased confusion, s/s of possible elopement as needed. 2. Convey an attitude of acceptance toward the resident. 3. Document about situation and complete elopement risk assessment with any increase in s/s of possible elopement risk, report such episodes to physician as needed. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS of 06, which indicated severe cognitive impairment. Section GG 120 - indicated Resident #1 used a walker (not accurate it was a cane). Section GG 170 - Mobility - Resident #1 is independent to walk 150 feet once standing the ability to walk at least 150 feet in a corridor or similar space. Wandering was not indicated for the lookback period for this MDS. Record review of Resident #1's progress notes dated 6/30/2023 - 3/20/2024 revealed the following: Elopement - 3/20/24 - found at hospital emergency room . Exit seeking - 1/29/24, 1/23/24, 10/3/23, 6/30/23. Wandering - 1/28/24, 2/13/24, 3/5/24, 8/20/23 Record review of Resident #1's admission Elopement assessment dated [DATE] revealed the following in part: Is the patient confused? Answer: Yes Does the patient/resident have a history of wandering? Answer: Yes Is the patient/resident ambulatory/propels self? Answer: Yes Does the patient/resident have a diagnosis that requires supervision? Answer: Yes Decision: Proceed or Do not proceed. There is no answer or intervention documented. Record review of Resident #1's progress note, dated 3/20/2024 at 7:10 PM (late entry 3/22/2024 at 4:14 AM) by RN A revealed the following in part . Resident observed not to be in facility he was located on a neighboring property (nearby local hospita) by staff and returned to facility . Record review of Resident 1's progress note, dated 3/20/2024 at 10:30 PM (late entry 3/22/2024 at 2:49 AM) by RN B revealed the following in part . On arrival to facility, patient (Resident #1) was not able to be located by staff, whom reported the concern .Nurse supervisor (RN B) made contact with ER staff at name hospital, patient was confirmed to haven admitted .returned to facility at approximately 9:30 PM . Record review of EMS run sheet dated 3/20/24 revealed Resident #1 was seen at 2:44 PM at an apartment complex (.4 miles away from facility) and transported to a nearby hospital. Resident #1 was transferred to the hospital's care at 2:59 PM. Record review of Resident #1's MAR dated 3/20/2024 revealed the following: Resident #1 was not administered Donepezil 10mg tablet (prescribed for dementia) at 7:00 PM on 3/20/2024. Reason: Not administered - Resident Unavailable. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was not administered Namenda 10mg tablet (prescribed for dementia) 7:00 PM on 3/20/2024. Reason: Not administered - Resident Unavailable. Interview on 3/27/2024 at 1:25 PM with DON, said she was notified approximately at 9:05 PM on 3/20/2027 when Resident #1 was not able to be located by RN B. The DON said staff should make rounds at least every 2 hours to ensure residents are present and if care is needed. The DON said all staff are responsible and should ensure residents are supervised and monitored. The DON said there is not a specific training or protocol that staff are trained on to confirm residents are present in the facility. Interview on 3/27/2024 at 2:15 PM ADON A said she worked on the day Resident #1 eloped from the facility. ADON A said she worked from approximately 9:00 AM to 9:00 PM. ADON A said she was normally in the office working and did not recall seeing Resident #1. She said Resident #1 wandered around the building daily. ADON A said the facility addressed his wandering by generally redirecting him (Resident #1). She said she was not able to give an exact time for when to round, but it should have been done every 1-2 hours. ADON A said staff should be mindful of Resident #1 because he wandered, which made him an elopement risk. ADON A said she was informed Resident #1 was missing when RN B arrived for his shift at approximately 7:45 PM. ADON A said she called Resident #'s family member to see if he was out on pass. ADON A said she received training on the elopement protocol, but there was no specific guidance regarding the frequency of resident being monitored during a shift. She said there was not a specific protocol on how staff members are monitored to ensure residents receive adequate supervision every two hours. ADON A said staff who worked directly with Resident #1 should have ensured he was present during their shift and if he was not seen, a Charge Nurse or ADON should have been notified. Interview on 3/27/2024 at 3:04 PM, RN B said he arrived at work at approximately 8:00 PM. He said he was told immediately by RN A that Resident #1 was missing. He said after they searched, he went to a nearby hospital to see if Resident #1 was there. He said he found the resident in the ER and brought him back, by car to the facility at approximately 9:05 PM. He said Resident #1 was not able to verbalize where he had been. He said Resident #1 had wandered out to the parking lot and was brought back in with no incident . He said it was not documented because the resident was easily redirected. He said Resident #1 would stand by exit doors. He said there was not an intervention to prevent Resident #1 from standing at the doors, but he would redirect Resident #1 when he wandered. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/27/2024 at 3:23 PM, CNA A said she was assigned to Resident #1 for the 2:00 PM - 10:00 PM shift on the day Resident #1 eloped. CNA A said she did not see Resident #1 at the beginning of her shift and assumed he was in another part of the building with family member. She said he normally wandered around the building. She said she was told by nursing staff to redirect Resident #1 if she saw him wandering. She said she was not aware of his care-plan interventions related to elopement risk. CNA A said she was not able to do shift change with CNA B due to her being late to work. CNA A said approximately at 4:30 PM, when she was passing meal trays, she asked at the nurse's station if anyone had seen Resident #1. She said she did not receive an answer and could not remember the staff that were around the nurse station. She said she did not alert staff at that time that she had not seen Resident #1. She said she continued with her work duties. She said between 7:30 PM and 8:00 PM she picked up the meal trays and saw that Resident #1's tray was in his room untouched. CNA A said CNA C said she had not seen Resident #1 during the shift either. CNA A said she looked with RN A in another area of the building and did not find him. She said she should have ensured the resident was present in the building when she was not able to locate him throughout her shift. She said she is supposed to round every 2 hours but during her rounds she did not see Resident #1. Interview on 3/27/2024 at 3:58 PM, CNA C said she worked the 2:00 PM - 10:00 PM shift when Resident #1 eloped. She said she was not assigned to Resident #1 and had not seen him during her shift. She said she was supposed to round every two hours for the residents she was assigned. She said she does not document if a resident was present, she would visually verify a resident is present. She said after dinner, approximately 6:30 PM, she was asked by CNA A if she had seen Resident #1 and she told her she had not. CNA C said she looked for Resident #1 with CNA A after dinner in other areas of the building and did not see him. She said she returned to her duties for her assigned residents for the rest of the shift. Interview on 3/27/2024 at 4:16 PM, RN A said she worked the 6:00 PM to 6:00 AM shift when Resident #1 eloped. She said arrived approximately 6:15 PM. She said she started medication administration and Resident #1 was not in his room and she remember his dinner tray in the rooms. She said she saw his cane as well and assumed Resident #1 was in the bathroom. She said she did not check the bathroom or verify if Resident #1 was present. She said she continued with the medication pass. She said she was alerted by CNA A that Resident #1 was not able to be located. She said all staff looked for the resident for maybe 30 minutes. She said she informed RN B that Resident #1 was not able to be located. She said she notified RN B at the start of his shift, approximately at 7:45 PM, that Resident #1 could not be located. RN A said we monitored residents by rounding and checking on them. RN A said we don't have a check off to document a resident is in the building, but she said there was a sign out sheet for residents out on pass. She said she did not check that sheet. She said residents with elopement risk do not have a specific monitoring schedule. Interview on 3/28/2024 at 11:20 AM, LVN A said had worked with Resident #1 before but not on the day he eloped. LVN A said Resident #1 would wander around the building, go into resident rooms, and go towards the exit doors at the end of the hallways. She said she would redirect Resident #1 when he was at the exit doors. She said there was not a protocol related to accounting for a resident visually or if a resident was in the building. She said they round every 2 hours but did not explain what is done if the resident is not seen every 2 hours. She said she thought one of Resident #1's interventions were frequent monitoring but was not sure. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/28/2024 at 12:20 PM, ADON B said it was common knowledge that a CNA would have learned in there CNA training to round every 2 hours and visually see residents to ensure they are supervised or monitored. ADON B said Resident #1 wandered the building and staff were instructed to redirect him. She said residents should be monitored to make sure they are in their rooms or the building but there was no specific documentation related to that. ADON B said she was not able explain why staff would not question where Resident #1 was during an 8-hour shift. Interview on 3/28/2024 at 2:20 PM, CNA B said she worked that 6:00 AM - 2:00 PM shift when Resident #1 eloped. She said she assisted Resident #1 up that morning and helped him to breakfast. She said it was normal for Resident #1 to wander around the building constantly. She said she had been trained to redirect Resident #1 when he wandered. She said she saw the resident eat lunch with his spouse approximately 11:30 AM - 12:00 PM. CNA B said she last saw Resident #1 approximately 1:45 PM, near the nurses' station watching TV on the skilled hall before she went to lunch. She said she did not return to that side of the building because she went to work on the long-term side for another shift. She said previously Resident #1 would attempt to the exit the long-term care exit doors when visitor would enter or exit the building. CNA B said she was instructed to redirect him. She said the DON, ADON or Charge Nurse were responsible and ensured CNAs supervised and monitored residents. Interview on 3/28/2024 at 3:22 PM, Administrator said the staff supervised and monitored residents by rounding. He said an example would be when staff completed medication administration. Administrator said Resident #1 would be monitored throughout the halls as he wandered. He said there was no specific training or policy to ensure resident was present in the building throughout the shift. He said he expected staff to round every 2 hours to monitor resident. He said he was informed approximately after 8:00 PM that Resident #1 was unable to be located. Administrator said he interviewed the staff that worked 2:00 PM - 10:00 PM. He said they reported on the day Resident #1 eloped and they did not find it weird or report the resident was missing because he wandered a lot and they thought he may have been with his on pass. Administrator said there was no sign in and out sheet for residents on pass . He said he did not know how staff tracked residents out on pass. Administrator said the CNA's and Nurses were responsible for ensuring residents were supervised during the shift. Administrator said it was the CNA's and Nurses responsibility to ensure the residents are present in the building and they should have rounded to monitor residents location. Interview on 3/28/2023 at 4:03 PM, ADON B said she was not sure who was responsible and reviewed the sign-in and out sheet for residents out on pass. She said she was not sure if staff reviewed the sign in and out sheet to verify if Resident #1 was out on pass. Observation on 3/28/2024 at 5:20 PM revealed, the main street to the facility had moderate traffic with fast moving vehicles. The main street had 3 unhoused citizens asking for money. The main street (four lanes) to the facility had posted speed limits of 35 mile per hour. The apartment complex that Resident #1 was seen at by EMS was .4 miles away from the facility. Record review of facility out of facility/on pass Sign in and out Sheet for residents dated March 2024 revealed two names on the form and it did not have Resident #1 on it. In an interview 3/28/2024 at 3:22PM, Administrator said the facility did not have a policy on supervision or how residents were monitored by staff throughout a shift . (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Elopement assessments completed in the past 90 days on current residents in the facility will be reviewed by nursing managers for accuracy on 3/28/24. Any not completed in past 90 days or found to be inaccurate will be completed by the DON on 3/28/24. None were identified as inaccurate. Identified residents at risk will be reviewed using the Elopement Risk Assessment for interventions on 3/28/24, by the Director of Nursing and any issues identified were corrected at the time of discovery. Care plans were updated to reflect the interventions by the Nurse Assessment Coordinator on 3/28/24. 10 residents identified as an elopement risk had their care plan updated. Facility Doors were validated to be in proper working order by Maintenance Director on 3/28/24. Facilities Plan to ensure compliance quickly Licensed Nurses will be reeducated on Accidents and Incidents, the elopement risk assessment process/accuracy and putting interventions in place based on the risks identified, which may include every 6-hour documentation to validate the resident's location. Nursing Staff will be reeducated on resident care and the elopement policy that includes. - o Checking for residents needs approximately every 2 hours. - o Validating during shift change resident's location. - o Notifications to Charge Nurse or Director of Nursing as indicated when a resident is not located. This reeducation will be completed by the Director of Nursing/Designee on 3/28/24. Any member of the target audience not receiving this reeducation by 3/28/24 will receive prior to their next scheduled shift. This will be presented in New Hire Orientation. An elopement drill will be completed on 3/29/24 that includes: - o The Administrator will notify the Charge Nurse, Director of Nursing and Social Service Designee that a resident is missing. The Director of Nursing/designee will announce Code [NAME] to signal the Elopement Drill Procedure - o The Director of Nursing/designee will organize an immediate and thorough search of the center and surrounding grounds. The entire search process will be completed within 30 minutes - o If the search fails to locate the missing resident in the allotted time, the Administrator/designee will place a mock telephone call to the appropriate community agencies, resident's legal representative and attending physician. Staff will provide the mock police with all the physical identifying information. - o The search will continue if resident not located to include 2 staff members searching the surrounding streets by car for a 2 mile radius (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Crimson Heights Health & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 19279 McKay Dr. Humble, TX 77338	
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	o When the volunteer resident is located the Charge Nurse will complete a head to toe assessment. The Social Services Designee will assess the resident for emotional distress. The Director of Nursing will notify the appropriate community agencies, attending physician and the resident's legal representative. o The facility's Quality Assurance Committee will investigate the incident and implement interventions to prevent reoccurrences. o When the missing resident is found, an announcement will be made, Code [NAME] all clear. The Medical Director was notified of the Immediate Jeopardy on 3/28/24. Ad Hoc Quality Assurance and Performance Improvement Meeting was held on 3/28/24 to discuss contents of this plan. 9:30am-Record review of the listed residents Elopement risk seemed to be current and accurate. 10:15am-Record review of Inservice Title: Resident Monitoring/Incident/Accidents/Elopement. The Inservice was developed by DON on 03/27/24. o Round q 2 hours during general rounds, attention to those at risk for wandering/elopement. o Charge nurse does q 6-hour location verification in the record. o Check for location of at-risk residents during change of shift rounds. o Notify Charge Nurse/ADON or DON if resident is not located during this process o Nurse performs Elopement assessment, if identified as an elopement risk, the resident profile is updated, the MDS team will care plan with interventions. ADON/DON is notified. o NOTIFY DON/ADMINISTRATOR IMMEDIATELY IF A RESIDENT IS NOT LOCATED ON INITIAL SEARCH. 10:47am-The following staff were interviewed regarding In-Service Resident Monitoring/Incident/Accidents/Elopement. Staff were able to answer questions in a satisfactory manner and did not raise any concerns. 10:50am-Interview conducted with LVN D. 10:55am-Interview conducted with Restorative aide A. 11:00am Interview conducted with CNA D. 11:06am-Interview conducted with LVN B. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:11am-interview conducted with ADON A. 11:15am-Interview conducted with LVN C. 11:20am-Interview conducted with CNA E. 11:24am-Interview conducted with Med Aide A. 11:30am-Interview conducted with CNA F. 11:36am-Interview conducted with CNA G. 11:45am-Interview conducted with LVN D. 11:50am-Interview conducted with CNA H. 12:00pm-Observations of staff and resident's interactions during lunch and on hallways did not raise any concerns and residents were being appropriately supervised. Residents were dressed appropriately none of the residents appeared to be in distress. Also while rounding observations were made of exit doors and all doors appeared to be secure and were fitted with an alarm in case of anyone exiting the door. 12:30pm-Record review of facility documentation from Maintenance Director dated 03/28/24 indicated that all exit doors were checked on 03/27/24 and were in working order. 1:00pm-Record review of document titled Elopement Drill indicated that an Elopement Drill was conducted on 3/28/24 with 16 staff and RN B conducted the drill. 1:10pm-Attempted to call RN B for interview but was unable to reach him. 1:15pm-Interview with DON revealed that she wrote the Inservice and that she in-serviced staff on Service Resident Monitoring/Incident/Accidents/Elopement.] An Immediate Jeopardy (IJ) was identified on 3/28/2024. The IJ template was provided to the Administrator and DON on 3/28/2024 at 5:12 PM While the IJ was removed on 3/29/2024 , the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need evaluate the effectiveness of the corrective systems.		