STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676480	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caraday Mesquite	825 W. Kearney Street Mesquite, TX 75149

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** 44021 Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (Resident #1) of 3 residents reviewed for elopement risk. On 05/08/24 around 2:00 PM, Resident #1 was found 1/4 of a mile from the facility walking on the sidewalk of a two-lane road going into a residential area, after he had eloped from the facility while wearing a wander guard and at the facility for respite care. The non-compliance was identified as PNC. The IJ began on 05/08/24 and ended on 05/10/24. The facility had corrected the non-compliance before the survey began. This failure could place residents who used wander guard at risk for serious injuries. The findings were: Record review of Resident #1's face sheet, dated 05/07/24, revealed that Resident #1 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), Dementia (a general term for impaired ability to remember, think, or make decisions), Glaucoma bilateral (A group of eye conditions that can cause blindness, both eyes), and Conductive-hearing Loss, bilateral (soundwaves are disrupted anywhere along the pathway to the tympanic membrane). Record review of Resident #1's MDS assessment, dated 05/08/24 revealed a BIMS score of 99 which denoted a staff assessment of mental status, Resident #1 was indicated to have a memory problem, and was found to be severely impaired for daily decision making and disorganized thinking. Record review of Resident #1's May 2024 Physician orders revealed an order dated 05/07/24 that stated Monitor wander guard to left ankle every shift for placement. Elopement risk. Record review of Resident #1's Care Plan dated 05/07/24 revealed The resident is an elopement risk/wanderer related to Alzheimer's diagnosis. The Care Plan Goal stated, The resident's safety will be maintained through the review date. The Care Plan Interventions stated, Distract resident from wandering by offering diversions, structured activities, food, conversation, television, book. (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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NAME OF PROVIDER OR SUPPLIER Caraday Mesquite		STREET ADDRESS, CITY, STATE, ZIP CODE 825 W. Kearney Street Mesquite, TX 75149	

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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 progress notes dated 05/07/24 at 1:53 PM Orders-Administrative stated, Monitor wander guard to-left ankle-every shift for placement. Elopement risk .every shift related to Alzheimer's disease. Record Review of Resident #1's progress notes. 05/07/24 at 3:53 PM written by ADON stated, Resident [#1] admit from home hospice care Diagnosis, Alzheimer's, respite care x 5 days, alert and oriented x2, confused and wanders asking where is his car. Verbal consent given to place wander guard to left ankle by a resident representative. Record review of Resident #1's progress notes dated 05/08/24 at 5:38 PM written by LVN J stated that At approximately 1:00 PM DON was notified by staff that they were unable to locate resident [#1] during last round on first shift. DON in facility and assisted with search. Elopement plan of action initiated. Facility and premises search initiated, resident headcount performed, and multiple parties notified including MD, Family, hospice, and Administrator. Resident has a wander guard in place to left ankle and is high risk for wandering. Resident found safe wandering in neighborhood behind nursing facility and EMT/911 on the scene. No injuries noted, no emotional distress noted, no treatments, medications, or meals missed. Resident [#1] checked out by EMT/911 on the scene and escorted back to facility by 911 on stretcher. Head to toe assessment performed and no new skin issues noted. All vitals WNL and Resident [#1] denies pain. Record review of the weather archive website (timeanddate.com) for the weather at the location of the facioity on 05/08/24 reflected that the temperature on 05/08/24 was documented to be 88 degrees Fahrenheit at 1:50 PM and 90 degrees Fahrenheit at 2:53 PM. Record review of an in-service, dated 05/08/24, facilitated by ADON and entitled Staff Education on Door Entry with objectives identified as; All staff enter and exit out/in of front entrance door, Do not enter/exit out of any other exit doors on any of the halls, Ensure doors are closed behind you, Response to door alarms (staff). The in-service was signed by 55 employee including ADON. Record review of an in-service, dated 05/08/24, facilitated by ADON and entitled Wandering/Elopement Emergency Procedure with objectives identified as; Wandering/Elopements, Emergency Procedure, Elopement Binder location on/at Nurses station. The in-service was signed by 55 employees including ADON. Record review of an in-service, dated 05/08/24, facilitated by ADON and entitled Missing Resident Drill, with objectives listed as; Actual Missing Resident Drill. The in-service was signed by 55 employees including ADON. (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 the facilities PIR, dated 05/14/24, revealed on 05/08/24 at 2:15 PM that .while nursing staff were completing final round prior to the end of their shift, they noted Resident [#1] was not in his room nor in center . Assessment was completed on 05/08/24 at approximately 2:15 Pm by ADON and a head-to-toe assessment was completed. No injuries noted. Provider response was emergency procedure of missing person initiated. All available staff searched inside and the immediate vicinity of the center. Resident located in neighborhood near center. Once resident located and brought back to center, resident placed on one-to-one observation. Family members notified. Medical Doctor notified. Hospice notified. Head-to-toe assessment completed. Door alarm provider notified to complete visit to ensure door alarms functioning properly. Resident headcount performed throughout center to ensure no other residents were missing, no other residents noted missing. In-services related to: Missing Resident, Entry and Exit of staff, Emergency Procedures related to missing residents, and elopement binder location. Additional exit door alarms purchased for hallway exit doors. Based on staff interviews it could not be determined how resident was able to elope from center. Ad-Hoc QAPI meeting completed. Wander risk assessments updated on all residents at risk for elopement. Record review of Exit Door Safety Monitoring Logs dated from 05/09/24 to 05/30/24 revealed that all exits were monitored by staff every 2 hours for alarm function and that each door were secure. Record review of a document identifies as an invoice for a door alarm company dated, 05/10/24 revealed that a new wander guard system and bracelets were purchased, installed, and tested at the facility. Record review of a document entitled AD-Hoc QAPI Meeting, dated 05/08/24 at 3:00 PM revealed that the QAPI committee met with all attendants required participating. During an interview with ADON on 06/25/24 at 11:07 AM, ADON revealed that Resident #1 had been at the facility for respite, and that Resident #1 had somehow gotten out of the facility at shift change. Resident #1 did not have his wander guard on him when he was located outside of the facility. That Resident #1 must have somehow got his wander guard off and was possible let out by a family member. She stated that the doors all alarm if the bar was pressed too long or if the door was opened without the keypad code. In an observation and interview on 06/25/24 at 12:21 PM with the Maintenance Manager it was observed that all entry/exit points in the facility had doors that were secure, had functioning alarms and were posted with notices that that alarms will sound if door was opened. Wander guard monitors were noted to be mounted at each exit. The Maintenance Manager stated that all the wander guard monitors had been replaced with new ones on 05/10/24. During an interview on 06/26/24 at 9:13 AM CNA B stated that she had attended all of the in-services related to Resident #1's elopement. She stated that she pays a lot more attention to doors. She identified where the elopement binder was and what it was used for. She stated that the staff did two-hour checks on all of the doors. She stated 5 different ways to redirect residents that wandered and to report such behavior to a nurse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/26/24 at 9:21 AM CNA C stated that that she had attended all of the in-services that were related to Resident #1elopement. She identified five different ways to redirect residents that wander. She stated that the elopement binder was marked Elopement and was located at the nurse's station and it contained all of the procedures to follow if a resident elopes. She stated that the staff had to do 2-hour checks on all of the exits for a while. During an interview on 6/26/24 at 9:29 AM CNA D stated that he had attended all of the in-services related to Resident #1's elopement. He stated that he had learned some new ways to redirect residents that wander, and he named five different ways to redirect residents that wander. He stated that the Elopement binder with all of the instructions about elopements was located behind the nurse's station. During an interview on 06/26/24 at 2:36 PM LVN B stated that the staff all had to conducted 2 hour checks on all exits, that she had attended all of the in-services related to Resident #1's elopement. She stated that all residents identified as wander/elopement risk had been reassessed and all wander guards are checked every shift, sometimes more. She stated that the CNA's have all been very good at telling the nursing staff if there are any exit seeking behaviors. During an interview on 06/26/24 at 2:44 PM MA E revealed that he had attended all of the in-services related to Resident #1's elopement. He stated that he had worked with Resident #1 for the day that Resident #1 was at the facility, and that he had seen the nurses and CNA's redirect Resident #1 several times and that he had redirected Resident #1 also. He stated that the Elopement binder had all of the elopement protocols in it and that the binder was located behind the nurse's station. He was able to identify 5 ways to redirect wandering residents. During an interview on 6/26/24 at 3:45 PM CNA F she had been working the day that Resident #1 had eloped, she stated that it had been scary and that they all had gone looking for him. She stated that they found him about 10 minutes after they started looking for him and that he had been found just around the corner from the facility. She stated that she had attended all of the in-services related to Resident#1's elopement, she was able to name 5 different ways to redirect wandering residents. She was able to name what was in the Elopement binder and where it was located . A record review of the facility's policy titled Wanderer Management, Monitoring System & Resident Elopement Protocol, last reviewed date 01/2023 , reflected Purpose: To provide a system to alert staff that a resident may be attempting leave the facility. Policy: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible . Procedures: 4. Residents identified as risk for elopement shall be provided one of the following: a. Door alarms on exit doors. b. A personal safety device that alerts staff of resident effort to leave the facility. c. Signaling device to the arm or angle or as permitted by the manufacturer . The noncompliance was identified as past noncompliance IJ. The noncompliance began on 05/08/2024 and ended on 05/10/2024 when wander risk assessments for all residents identified as wander risk and wander guard bracelets were checked for placement on 05/08/24. In-services regarding Elopement Risk with all staff were initiated on 05/09/24 and completed on 05/10/24. Exit Door alarms were checked every two hours 05/08/24 to 05/30/24. Wander guard bracelet system replaced, and new bracelets distributed to at risk residents completed on 05/10/24.