STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675066	A. Building B. Wing	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Honey Grove Nursing Center	1303 E Main St Honey Grove, TX 75446

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** 44637 Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards and each resident was provided adequate supervision to prevent elopement for 1 of 14 residents (Resident #1) reviewed for accident hazards. The facility failed to ensure Resident #1 window would not open greater than 6 inches. The facility failed to ensure Resident #1 was provided appropriate supervision to prevent further elopement. This failure resulted in an identification of an Immediate Jeopardy (IJ) at 5:04 p.m. on 7/26/22. While the IJ was removed on 7/28/22, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of suffering heat related illness or injury/death from a vehicle accident. Findings included: 1. Record review of the consolidated physician orders dated 7/28/22 indicated Resident #1 was a [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including psychotic disorder with delusions (serious mental illness called a psychotic disorder). Record review indicated the comprehensive MDS was not complete on Resident #1 due to resident being newly admitted to the facility. Record review of the care plan dated revised on 7/26/22 indicated Resident #1 was exit seeking. The care plan indicated Resident #1 had an elopement through his room window with interventions including every 15-minute checks and finding more secured placement. Record review of the elopement assessment dated [DATE] indicated Resident #1 was a high risk for elopement with a score of 15. (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	Record review of the secured unit assessment dated [DATE] indicated Resident #1 required placement on the secured unit due to habitual wandering, wandering out of building and unable to find their way back, and was exit seeking. Record review of the nursing progress note dated 7/222/22 at 5:59 a.m. indicated Resident #1 was angry and belligerent with staff. The nursing progress note indicated Resident #1 stated we wanted to leave the facility and would break the door down to do so. The nursing progress noted indicated Resident #1 had hit the glass window on the door until he broke through the glass. Record review of the nursing progress noted date 7/23/22 at 6:21 a.m. indicated Resident #1 became increasingly agitated. Resident #1 tried to escape out the window. Resident #1 got out into the secured courtyard and tried squeeze through the fence. Record review of the nursing progress note dated 7/23/22 at 7:35 p.m. indicated LVN A had been alerted by the CNA Resident #1 had eloped from the facility through his bedroom window. The nursing progress noted indicated LVN A notified the Administrator of the elopement and staff searched the parameter of the facility. The nursing progress noted indicated LVN A got in his vehicle to look for the resident. The nursing progress note indicated LVN A found Resident #1 on foot walking down Main Street/Highway 56 headed towards downtown. The nursing progress note indicated LVN A was able to convince Resident #1 to return to the facility with him. The nursing progress note indicated LVN A performed a head-to-toe assessment on Resident #1 upon getting Resident #1 back to the facility. The nursing progress note indicated LVN A offered Resident #1 water which he took liberally. Record review of the provider investigation report dated 7/23/22 indicated Resident #1 eloped from the facility by prying the window in his room open. The provider investigation report indicated Resident #1 was found to be missing on 7/23/22 at 7:35 p.m. and found at 7:44 p.m. The provider investigation report indicated staff were in-serviced on monitoring residents on the secured unit at all times and the CNA assigned to the unit must notify the nurse before leaving residents unattended. The provider investigation report indicated Resident #1 had been on every 15-minute check 7/23/22 from 3:15 a.m. until 7:00 a.m. The provider investigation report indicated Resident #1 was on one-on-one observations on 7/24/22. The provider investigation report indicated Resident #1 was put back on every 15-minute checks on 7/25/22. Record review of the weather for 7/23/22 at www.worldweatheronline.com indicated the temperature in Honey Grove, TX was 100.4 degrees Fahrenheit at 6:00 p.m. and 93.2 degrees Fahrenheit at 9:00 p.m. Record review of the nursing progress note dated 7/26/22 at 11:22 p.m. indicated Resident #1 was observed being agitated and constantly asking staff how to get to the highway. The nursing note indicated Resident #1 was packing his belongings and walking around the unit with his bag, asking staff when he could leave. Record Review of the facility's 15-minute Face Checks indicated Resident # 1 had been placed on 15-minute checks on 7/23/22 at 3:15 a.m. The 15-minute Face Checks indicated the 15-minute check on Resident #1 had continued from 3:15 a.m. until 7:00 a.m. on 7/23/22 and then stopped. The 15-minute Face Checks indicated Resident #1 had been on 15-minute checks again on 7/24/22 at 3:15 a.m. until 5:45 a.m. The 15-minute Face Checks indicated on 7/24/22 at 6:00 a.m. Resident #1 had been placed on one-on-one observations until 7/25/22 at 3:15 a.m. The 15-minute Face Checks indicated Resident #1 was placed back on 15-minute checks on 7/25/22 at 3:15 a.m. (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 facility's Wander Book had a copy of Resident #1's face sheet with picture and the facility's elopement policy. During an interview on 7/26/22 at 10:22 a.m. CNA B said Resident #1 was confused and wanted to return home. CNA B said she had not witnessed Resident #1 attempting to exit the facility. CNA B said there was one CNA assigned to the unit for 14 residents. CNA B said there were three exit doors in the unit all with alarms (one to the secured courtyard, one to the main area of the facility, and one to an unsecured area outside). During an observation on 7/26/22 at 10:28 a.m. Resident #1's window in his room was able to open all the way and was not facing the secured courtyard. Resident #1's window faced the side of the building and a parking lot area. During an observation on 7/26/22 at 10:32 indicated the speed limit on Main Street/Highway 56 in front of the facility was 55 miles per hour. During an interview on 7/26/22 at 12:15 p.m. Resident #1 said he wanted to go to Dallas, TX. Resident #1 said he lived in [NAME], TX. Resident #1 said he had got into a fight with his brother where his brother hit him in the back of the head, knocked him out, and brought him here. Resident #1 said his brother had his wallet with is resident card (Green card granting permission to live and work in the United States). Resident #1 said if immigration came, they would send him back to Mexico. Resident #1 asked for directions to Dallas, TX. During an interview on 7/26/22 at 12:25 p.m. LVN A said he had been passing medications when the CNA (CNA E) working the secured unit informed him of Resident #1 eloping. LVN A said Resident #1 had raised the window to his room and climbed out the window. LVN A said he found Resident #1 walking towards town. LVN A said up until the elopement he had not been the nurse assigned to the secured unit and was unfamiliar with Resident #1. LVN A said the CNA (CNA E) working the unit provided 15-minute checks on Resident #1 after his elopement. During an interview on 7/26/22 at 12:40 LVN C said she was an agency nurse, and it was her first shift at the facility. LVN C said she was the nurse assigned to the unit. LVN C said Resident #1 had not had any exit seeking behaviors this shift. LVN C said Resident #1 was on every 15-minute checks. During an interview on 7/26/22 at 12:46 p.m. the SW said Resident #1 had not been referred for psychiatric or social services. During an interview on 7/26/22 at 12:53 p.m. Resident #1's family member said Resident #1 had a history of eloping from facilities. Resident #1's family member said he had eloped 5 or 6 times from a previous facility. Resident #1's family member said Resident #1 was a master electrician and had disarmed a door alarm at a previous facility. Resident #1's family member said Resident #1 would ask multiple times a day about his wallet and resident card. Resident #1's family member said Resident #1's previous physician had diagnosed him with alcohol induced dementia with amnesia. (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 7/26/22 at 1:05 p.m. LVN D said she had worked 7/23/22 and 7/24/22 on the 6:00 a.m. to 6:00 p.m. shift and had been the nurse assigned to the secured unit. LVN D said Resident #1 had exhibited exit seeking behavior on both days. LVN D said Resident #1 asked about going home, his wallet, and his wife. LVN D said Resident #1 required continuous redirection. LVN D said Resident #1 was on one-on-one observation on 7/24/22. LVN D said they monitored one-on-one observations by documenting on a printed form that the resident was being observed and by who. During an interview on 7/26/22 at 1:12 p.m. CNA E said he worked 7/23/22 the 6:00 p.m. to 6:00 a.m. shift on the secured unit. CNA E said Resident #1 was sitting on the couch of the day room in the secured unit when he took another resident to the restroom. CNA E said he was in the restroom with the other resident approximately 10 minutes. CNA E said when he came out he could not find Resident #1. CNA E said he discovered Resident #1's room window raised and he notified the charge nurse. CNA E said Resident #1 had not been on every 15 minutes checks prior to his elopement. CNA E said Resident #1 had attempted to elope from the facility the day before on 7/22/22. CNA E said Resident #1 was easily redirected. During an interview on 7/26/22 at 1:28 p.m. the DON and Administrator said they were unaware of Resident #1's history of elopement prior to him admitting to the facility. The DON and Administrator said they found out from Resident #1's family after his admission to the facility about Resident #1's history of eloping. The DON and Administrator said Resident #1 was put in the facility elopement book, placed on the secured unit, and staff were made of aware of his exit seeking behavior on admission. The DON and Administrator said no interventions had been put in place to Resident #1's window after his elopement. The DON and Administrator said Resident #1's window had initially had clamps to prevent the window from being opened all the way, but Resident #1 had broken the clamp. The DON and Administrator said the maintenance supervisor had ordered more clamps for the windows. The maintenance supervisor was off work and unable to be interviewed on 7/26/22. During an interview on 7/26/22 at 3:15 p.m. the Administrator said Resident #1 had been taken off one-on-one observations on 7/25/22 because he had settled down and was sleeping. During an observation on 7/26/22 at 3:32 p.m. all windows in the rooms on the secured units had clamps in place prohibiting them from raising up all the way except Resident #1's window. Record review of the facility's undated Wandering/Missing Residents policy indicated, .The facility must ensure the resident's safety while utilizing the least restrictive means available. To meet this, need the facility will obtain information during pre-admission or admission conferences with the resident and family regarding any history of wandering or the potential for wandering .The resident's name, picture, and physical description are placed in the wander book located at the nurse's station. All staff are responsible for knowing whose name is on the list and be able to recognize the resident and be able to intervene a necessary .Upon return to the facility (after and elopement), the resident will be assessed for injuries and the attending physician will be advised of the situation. A thorough incident report will be filled out by the charge nurse and given to the Administrator . The administrator was notified on 7/26/22 at 5:04 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The administrator was provided the Immediate Jeopardy template on 7/26/22 at 5:10 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's Plan of Removal was accepted on 7/27/22 at 5:02 p.m. and included: Facility Administrator, with assistance from the Maintenance Director, ensured Resident #1's bedroom window was secured mechanically only to raise 4 inches on 7/26/22. This was done by securing an L bracket to the wall with screws and restricting the window movement to four inches. Facility Administrator, with assistance from the Maintenance Director, ensured that all other windows, (22 total) including other residents bedroom windows were secured mechanically to only raise 4 inches on 7/26/22. Facility Administrator, with assistance from the Maintenance Director, physically placed a permanent marking on the facing of the window at the 4-inch mark where the secure mechanism was placed for ease of visual validation by staff on 7/26/22. Facility Administrator and DON will ensure that the staff will receive in-services regarding ensuring that windows on the secured unit have the mechanism for ensuring the windows ability to not open past the 4 inch mark, Elopement policy and procedures, identification of wandering/exit seeking behavior and intervention techniques, and understanding that all windows on the secured will have mechanism in place that the windows are unable to open past the 4 inch mark and that it is mandatory to report any deviation from this to the Administrator or designee immediately. On 7/28/22 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During an observation 7/28/22 at 8:30 a.m. Resident #1's window was equipped with an L-bracket attached by screws to prevent his window from raising past 4 inches. Interviews of nursing staff (3-nurses on the 6:00 a.m.-6:00 p.m. shift; 2-nurses on the 6:00 a.m.-6:00 p.m. shift; 2-CNAs on the 6:00 a.m.-6:00 p.m. shift; 2-CNAs on the 6:00 p.m.-6:00 a.m. shift, 1-Physical Therapy Assistant; 1-Housekeeper; 1-CMA on the 6:00 a.m-6:00 p.m. shift; and 1-Social Worker) were performed. During these interviews' staff were able to correctly identify steps to take in the event of an elopement per the facility's policy, types of exit seeking behaviors, interventions for exit seeking behaviors, understanding of the windows in the unit's physical mechanisms to prevent them from opening more than 4 inches, the for the windows to be checked daily and where to document the checks, and the immediate need to notify the Administrator or designee of any deviation of the physical mechanism on the windows on the secured unit. On 7/28/21 at 11:10 p.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at a potential for more than minimal harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.