STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676178	A. Building B. Wing	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Duncanville Healthcare and Rehabilitation Center	419 S Cockrell Hill Rd Duncanville, TX 75116

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** 37028 Based on observation, interview, and record review the facility failed to provide adequate supervision and devices to prevent accidents for 1 (Resident #1) of 4 residents reviewed for accidents and supervision. The facility failed to ensure Resident #1 was provided with supervision resulting in him eloping from the facility on 03/18/23. Resident #1 was found approximately 5 miles away at a convenience store by Emergency Medical Services (EMS). The resident was taken to the hospital and required hospitalization for altered mental status and unknown infection. An Immediate Jeopardy IJ)was identified on 03/19/23 at 2:50 PM. While the (IJ) was removed on 03/22/23 at 1:30 PM, the facility remained out of compliance at a severity level of actual harm that was not Immediate Jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed all residents that are an elopement risk at risk for serious injury, harm, and/or death. Findings included: Review of Resident #1's MDS assessment, dated 01/12/23, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 9 meaning he had moderately impaired cognition. The resident required one staff assist for transferring. The resident required supervision for walking and locomotion on/off the unit. The resident required 1 person assist for toilet use and hygiene. The resident was occasionally incontinent of bowel and bladder. The resident did not have any behaviors. The resident's diagnoses included Wernicke's Encephalopathy (disease that leads to confusion, loss of mental activity, and loss of muscle coordination), Parkinson's Disease (brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), and a seizure disorder . Review of Resident #1's Care Plan reflected the following: 09/26/22 Resident is exhibiting exit seeking behaviors by stating he no longer wants to live at facility. Wander guard placed on right ankle. (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	Facility interventions included: Check resident location frequently, wandering alert bracelet to be checked by nurse every shift. If bracelet is removed, replace or place on increased monitoring of whereabouts. Observe for verbalizations of wanting to leave/go home. Review of Resident #1's Physician Orders reflected the following: 09/26/22 Wander Bracelet related to wandering/exit seeking behaviors. Nurse to check placement and function every shift including skin check under bracelet. Location of bracelet on resident: right ankle Review of Resident #1's progress notes reflected the following: 03/18/23 at 2:25 AM Late Entry: Patient (Resident #1) was not observed in his room, and on investigation, his roommate stated that patient informed him that he would be going to South Dallas to visit a friend. Patient wears an ankle wander guard bracelet, and it was noted that he has taken it off and he wrapped it up and put on top of toilet roll paper and put it in his drawer. The DON, Administrator, Physician, and Police was notified. Staff Immediately did a search of the whole building, rooms and surrounding areas, called the hospital and business, drove the streets. Patient is his own responsible person. - Weekend Supervisor. Review of Risk Elopement Assessment for Resident #1 reflected: 12/19/22 High Risk for Wandering . Review of the Police Report for Resident #1 reflected: [AGE] year-old male diagnosed with Parkinson's left the location. Male listed as missing. Male found. Reported 03/18/23 6:59 PM. Cleared 03/20/23 10:52 AM An interview with the DON on 03/19/23 at 1:00 PM, the DON revealed Resident #1 eloped from the facility on 03/18/23 . She said the resident was oriented x2 and his own responsible party. The DON said the resident was found by EMS at a convenience store approximately 5 miles away from the facility. She said she had spoken to the resident, and he said he left the facility because he needed a break and was still in the hospital. The DON said the facility did not have a secure unit but did have a wander guard system in place. The DON said Resident #1 took off his wander guard bracelet before eloping from the facility. The DON said the resident wore the wander guard because he was at risk for wandering. The DON said a little after 2:00 PM on 03/18/23 the resident left the facility, and the security doors were working at that time. He was found sometime between 5:00-6:00 AM on 03/19/23 by EMS. She said she did not know how he eloped from the facility because all the doors required a security code to exit and enter the facility . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An observation on 03/19/23 at 2:25 PM, of Hall 200 with CNA A revealed there were two sets of doors that had to be opened to go to the smoking area. The 2nd door had a security code pad and CNA A entered the code to open the door. The smoking area had sidewalks and a gazebo. There was no fence or barrier to prevent residents from walking to the front of the building. CNA A said on 03/18/23 construction painters were painting the interior area with the vending machines when she arrived for her shift at 2:00 PM. She said later she saw the painters had barricaded the first door with the vending machines to paint behind them. An observation and interview on 03/20/23 at 2:30 PM, with Resident #1 revealed he was still in the hospital. He was in bed awake and alert and was oriented x2. (He knew who he was and where he was, he did not know what day it was or why he was in the hospital.) The resident was unable to recall specific events of his elopement. He did not remember being found. He said he took of his bracelet and left the facility. He said he was able to push the door (on Hall 200) open and go out the door. He said he did not have to enter a security code. He said residents frequently used that door to go outside to smoke. He said when he left the facility he wanted to go to South Dallas, get his government money and get his own place, but did not know how to do it. He said he did not know where he was going when he left the hospital, but did not want to go back to the facility because he did not like it. An interview on 03/20/23 at 2:40 PM, the Hospital RN assigned to Resident #1 reflected the resident was in the hospital for altered mental status and an infection (the nurse did not say what the infection type was). She said she did not know when or where the resident was going to be discharged to. She said the resident was alert and oriented x2. An interview on 03/19/23 at 2:30 PM with Resident #2 revealed he was awake, alert, and oriented x4. He said he saw Resident #1 go out the Hall 200 door on 03/18/23 after lunch while he was sitting outside. He said there were no staff outside and no one let Resident #1 out of the facility and no one followed him out of the facility. He said Resident #1 exited the facility by himself. Resident #2 said he was able to go out of the Hall 200 door by entering a security code to leave and another security code to re-enter. He said he saw Resident #1 with his coat and hat on and knew he was not supposed to be outside. He said he saw him go around the edge of the facility in his wheelchair. Resident #2 said he was seated in the smoking area at the gazebo in front of the laundry department . Resident #2 said he did not tell anyone he saw the resident. An interview on 03/22/23 at 12:50 PM, CNA A revealed she was assigned to Resident #1 on the 2:00 PM - 10:00 PM shift on 03/18/23. She said she did rounds after starting her shift at 2:00 PM, but she did not see him. She said she thought the resident was in the front room of the facility. She said at dinner time (approximately 4:30 PM-5:00 PM), she put his tray in his room as she did every day. She said she went to pick up the tray and realized he had not eaten it. She notified LVN B at that time that she could not find Resident #1. She said staff started searching for him. An interview on 03/22/23 at 1:15 PM with LVN B revealed she was assigned to Resident #1 during the day and evening shift. She said she had checked his Wander guard and said it was in place before and after lunch (did not know exact times) on 03/18/23. She said the last time she saw the resident was after lunch. She said she identified he was missing when CNA A said he did not eat dinner (did not know exact time). LVN B said staff looked in all the rooms inside and outside the facility looking for the resident but could not find him. She said she notified the Weekend Supervisor. LVN B said Resident #1's roommate, unknown time, told him he was going to South Dallas to visit a friend. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 03/19/23 at 1:45 PM with the Weekend Supervisor revealed on 03/18/23 she saw Resident #1 at around 10:00 AM and he was in his room. She said at lunch time (did not know exact time) she saw Resident #1 at the nurse's station. She said around 4:30-5:00 PM CNA A reported she went to pick up the residents tray and noticed the resident was gone. The Weekend Supervisor said staff started searching the facility for him. She said Resident #1 had a wander guard, and while searching his room, they found it in his drawer. She said when staff could not find him, they called the police. She said the resident did not have a history of removing his wander guard. She said someone might have let the resident out of the Hall 200 door when they were going out to smoke. She said smoking residents knew the code to enter and exit the facility to smoke. She said the smoking area was not fenced and anyone could walk around the building. She said he told his roommate and had told residents before he wanted to go to South Dallas. An interview on 03/20/23 at 11:25 AM, with the Administrator revealed she had video footage showing Resident #1 outside of the building on 03/18/23. The video did not have a time stamp. The video showed Resident #1 in the courtyard. She said she spoke to Resident #3 and said he let Resident #1 out even though Resident #2 said no one followed or opened the door for Resident #1. The camera footage showed Resident #3 was outside. She said she did not know how Resident #1 eloped. An interview on 03/20/23 at 11:35 AM, Resident #3 revealed he was awake, alert, and oriented x3. The resident said he did not let Resident #1 out of the door and did not know why facility staff said he did. An interview on 03/20/23 at 11:40 AM with the [NAME] reflected he said they did not prop the Hall 200 door open while painting. An interview on 03/22/23 at 10:00 AM, the Administrator and DON revealed Resident #1 was still in the hospital. They said the facility should not be held responsible for the actions of Resident #1 because even though he had a BIMs score of 9 and had moderately impaired cognition the resident made a plan and executed it when he removed his wander guard. Record review of the facility policy, Wanderer Management, Monitoring System, and Resident Elopement Protocol, dated 01/17/18, reflected: It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible . This failure resulted in an identification of an (IJ) Immediate Jeopardy on 03/19/23 at 2:50 PM, the administrator was notified The IJ template was provided to the Administrator on 03/19/23 at 3:00 PM and a Plan of Removal (POR) was requested. The Plan of Removal reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Three residents with wander guards were observed wearing them. An interview on 03/22/23 at 12:40 PM with the DON revealed there were three residents who wore a wander guard, and they were assessed every shift to make sure they were wearing the wander guard. The door codes had been changed, and the facility doors were routinely checked to make sure the wander guard system was working. She said the facility systems in place to prevent elopement were the Wander guard system and the facility doors required a passcode to enter and exit. The DON said Resident #1 was not returning to the facility. An interview on 03/22/23 at 12:55 PM with the Administrator revealed three residents who wore a Wander guard. He said there were multiple assessments completed by the different departments. He said the nurses checked residents every shift to make sure they were wearing the Wander guard ankle bracelet. He said maintenance performed weekly checks on the doors and that all doors required a security code to enter and exit. He said that on-going monitoring would include interdisciplinary team meetings and weekend supervision. The administrator was informed the Immediate Jeopardy was removed on 03/22/23 at 1:30 PM. While the IJ was removed the facility remained out of compliance at a severity level of actual harm that was not Immediate Jeopardy and a scope of isolated, due to the facility still monitoring the effectiveness of their Plan of Removal.