DEPARTMENT OF HEALTH CENTERS FOR MEDICARE a			PRINTED:10/25/2016 FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455462	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2016		
NAME OF PROVIDER OF SU	455463	STREET ADD	DESS CITY STATE ZID		
	AME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP HE MEADOWS HEALTH AND REHABILITATION CENTER 8383 MEADOW RD DALLAS, TX 75231				
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing home or the state su	arvey agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST B MATION)	E PRECEDED BY FULL REGULATORY		
F 0224		d mistreatment, neglect and abuse of residents	s and theft		
Level of harm - Immediate jeopardy	Based on observation, interview a	S HAVE BEEN EDITED TO PROTECT CONF nd record review, the facility failed to implement #1) of one residents reviewed for neglect to prov	their policies and procedures that		
Residents Affected - Some	her room after finding her outside On [DATE], CNA F failed to noti	fy Resident #1's charge nurse, the DON and Adu without staff supervision. fy Resident #1's charge nurse, the DON and Adu g her outside on a patio without staff supervision	ministrator when she returned the resident to		
		#1 was found outside on the pavement face dowr	n with no pulse. CPR was initiated and continued		
	pattern with actual harm. The fact the investigation.	ncompliance Immediate Jeopardy that occurred o lity had implemented actions that corrected the n	on-compliance prior to the beginning of		
	placing them at risk injury, harm Findings included:				
	attempting to leave the premises, document the occurrence.	evised [DATE] reflected, It is the responsibility of or suspected of being missing, to the Director of	Nursing and the Administrator and to		
	resident to the facility, the Directo of Nursing); Contact the attending order [REDACTED]. records (Di safety measures to the Quality As		nine the resident for injuries (Director resident, and follow the physician's cloped and make recommendations regarding Committee and or the Safety Team Committee (as		
	Review of the facility 's Testing the door monitors and signaling devia internal batteries will be replaced will perform daily checks to verif will check the wristbands for tear conducted in the resident 's recor	nt 's care plan with interventions for elopement p he Wanderguard System, revised February 2010 r ces in the alarm system will be conducted to verif at least once a year or when the red light does no y the operation of the signaling device using a sig s or other damage and replace bands immediately d. Maintenance will inspect and test each door m	revealed, regular testing of Wanderguard y the integrity of the system. The t come on when pressed. Nursing staff gnaling device tester. Nursing staff if damaged and record the test was		
		d Neglect Prohibition Policy, revised [DATE], re buse, involuntary seclusion, injuries of unknown			
	Resident #1 's Closed Record refl Review of Resident #1's Care Plan diagnosed as an elopement risk/w function of safety monitoring dev revealed Resident #1 used a whee	ected on the Admission Record that she admitted h, dated [DATE], revealed Resident #1 was diagn anderer with impaired cognition on [DATE]. Inte ice every shift, identify pattern of wandering, and ichair for mobility. ssessment conducted on [DATE] revealed a score	osed with [REDACTED]. Resident #1 was rventions included check placement and 1 intervene as appropriate. Care Plan		
	#1 was mobile with a device, resi awareness, disturbances in judgm higher was considered at risk for	stant to long term care placement, was cognitivel ent, and had shown a history of elopement within elopement.	y impaired shown by decreased safety the past six months. A score of 12 or		
	at around 0620 laying down in he nurse met the resident on the hall- and administered her morning me breakfast. Resident was again see by this nurse. Around 1258 reside locate the resident within the unit active search began all staff was i on her back and facing up with al to elicit response from the patient assessment. I alerted one of the st alternated performing CPR until t	Note, dated [DATE] and completed by LVN A, r r bed during the initial morning rounds at the beg way by her room and I redirected her back into th dications as scheduled and per MAR. The resider n by this nurse around 0945 back in her room. The nt was noted missing from her room, this nurse a and nearby lounge but resident could not be seen nitiated both within and outside the building. Thi l extremities extended on the pavement just outsi both verbally and touch by shaking her but there aff to call 91 land get the crash cart while I starte he paramedics arrived to the scene about seven n	inning of the shift. Around 0720 this is room where I checked her blood sugar in then left for the dining room to get her his was the last time the resident was seen and the CNA working on the floor tried to h. Elopement code was activated and s nurse found the resident laying down de the building at around 1315. I tried was no response, no pulse upon d CPR. This nurse and one of nurses initutes later. Resident was pronounced dead		
	on the site by the paramedics. Thi on-call for the primary physician Review of the facility's Incident/ unresponsive, attempted to resusc no physical injuries were noted to Review of the facility's Investigati resident lying on a pavement with felt. CPR initiated. EMS called. S guard (sic) as a preventative meas	is nurse called the family and responsible party to was also notified about the incident. Accident Report, dated [DATE], revealed Reside itate pronounced dead by the paramedics upon a president. Family and physician were notified. on Follow-Up, dated [DATE] and completed by her wheelchair besides her not responding to cal kin assessed with [REDACTED]. CPR continuer sure from eloping. She had been re-directed sever	o notify them of the incident. Np nt was found outside the building rrrival. Incident/Accident Report revealed the DON, revealed, At 1310 (1:10 PM) found II. Lie (sic) face up. Assessed pulse not d until EMS arrived. Resident had a wander		
	hour routine checks. The DON re transitioned to long term care on t building. The facility would mon	DATE] at 11:45 AM, the DON revealed Residen vealed that when Resident #1 admitted to the faci the second floor. Resident #1 did have cognition a tor her wandering and re-direct her back up upsta incident. Resident #1 did not attempt to exit the	deficits and would wander throughout the airs to her room. Resident #1 did not have		
L					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X6) DATE

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.

 FORM CMS-2567(02-99)
 Event ID: YL1011
 Facility ID: 455463
 If continuation sheet

 Previous Versions Obsolete
 Page 1 of 6

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:10/25/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2016
	455463		
NAME OF PROVIDER OF SU THE MEADOWS HEALTH A	PPLIER AND REHABILITATION CENT		
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state	
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY
F 0224	OR LSC IDENTIFYING INFORM	MATION)	
Level of harm - Immediate	sidewalk beside the facility. Reside	[DATE], Resident #1 was found lying on her b dent #1 did not have any vital signs and the staf R, and then pronounced Resident #1 expired at	
Residents Affected - Some	notified. The facility did not know	w if an autopsy was performed or the cause of d	
	AM on [DATE], by nursing staff noted Resident #1 was not in her the sidewalk around 1:00 PM. Du that had occurred in the days just Resident #1 outside of the facility staff re-directed the resident back incident to their immediate super the following incident occurred in a separate occurrence. There was Wanderguard alarm due to the tw revealed the facility has two addi In an interview on [DATE] at 9:37 facility investigation residents rev regarding the time. All staff press in order to turn the Wanderguard denied entering the code in order conducted with residents that stat facility would then have to chang building. Review of CNA E's Witness State to 7:30PM when the alarms went upstairs. Interview by telephone with CNA around 7:00 PM due to the Wand the Wanderguard alarm from an eb building and re-directed her back being re-directed back into the bk Administrator about finding Resi regarding the incident. CNA E st supervisor, DON, or Administrate facility. Review of CNA F's Witness State that wander guard (sic) system w; (Resident #1) was sitting out on t 2-central. Interview with CNA F on [DATE when she was about to clock in. She im another resident. CNA F disabled froom. CNA F revealed Resident 4 stated she did not report finding F Administrator. CNA F disabled forom. CNA F disabled for stated she did not directly inft to report to her immediate superv attempting to leave the facility. Review of all staff in-service train residents, and elopement risks we in-service training, including staff facility staff from all shifts were Review of the Facility Elopement second, and third shifts. A total o with wandering/elopement risk we in-service training all shifts were Review of the Facility Elopement second, and third shifts. A total o with wandering/elopement risk we in-service training all shifts were Review of the Facility Elopement second and third shifts. A total o with wandering/elopement risk we in-service training all shifts were avale to identify behaviors to ideni On [DATE], the DON was notified the faci	y began an investigation on [DATE] which rev. on the second floor near her room. Around 12:: room. The staff initiated the missing resident p uring the investigation, she became aware of add prior to the incident on [DATE]. Two facilitys after hearing the Wanderguard alarm sound or inside to her room on the second floor. Both st visor, Director of Nursing, or Administrator. Th the morning on [DATE] prior to Resident #1 I no documentation regarding the first two instar o facility employees not reporting finding Resi tonal residents that have been identified as a w 0 AM, the ADON A stated the Wanderguard ala realed that they did hear the alarm go off, but cr ent during the incident involving Resident #1 I m alarm off. Residents that were present at the do to turn the alarm off when Resident #1 exited ti ed they heard the alarms go off were not consis e all the codes. The facility was in-serviced on ment, dated [DATE] revealed, On [DATE] I sa off I quickly ran and check (sic) I saw her and E on [DATE] at 1:40 PM revealed she found Fe erguard alarm going off. CNA E revealed she w exit door on the first floor. CNA E stated she im to the second floor. Resident #1 was in her whe uilding. CNA E stated she did not notify her im dent #1 outside of the facility. CNA E reported ated she was verbally counseled about the facili in immediately after finding a resident leaving t ment, dated [DATE] revealed, On [DATE] th 2d as going off on back patio went to see if any PT he back patio with another Pt. (patient) re-direcc] at 1:52 PM revealed on [DATE], she heard the mediately went to check the door and found Re the door alarm and re-directed Resident #1 inss #1 was in her wheelchair and did not appear to 1 Resident #1 outside of the facility to her immedia announced to the second floor that she brought orm any facility staff. CNA F stated she was ve isor, DON, or Administrator immediately after ing revealed in-services regarding keeping doo re conducted on [DATE] by ADON A. A total ATE] at 9:50 AM, CNA C revealed resident #1	30 PM, the staff were passing lunch trays and rotocol and found Resident #1 outside on ditional incidents of elopement by Resident #1 staff revealed that they witnessed 1 two separate occasions. Both facility aff members denied reporting either the first incident occurred on [DATE] and being reported missing later the same day on nees of Resident #1 setting off the dent #1 outside of the facility. The DON anderer/elopement risk. arm was working correctly on [DATE]. During the outld not provide specific details of issing on [DATE], denied entering the code or that Resident #1 exited the building the building. Follow up interviews were stent with previous interviews. The being secure with the codes to exit the with grevious interviews. The being secure with the codes to exit the with grevious interviews are the hours of 7 I re-directed her and she followed me back. Resident #1 outside of the facility on [DATE] vas downstairs on her lunch break when she heard mediately brought Resident #1 inside the eelchair and did not provide any resistance mediate supervisor, THE DON, or sub did not inform any facility staff ty policy to report to her immediate the facility or attempting to leave the D16 when I clocked in at .[DATE] AM notice (sic) C (Physical Therapist) was outside noticed ted back upstairs to .unit on e Wanderguard system going off around 7:00 AM esident #1 outside on the back patio with ide the facility and back upstairs to her rbally counseled about the facility policy finding a resident leaving the facility or triang distress, only confused. CNA F iate supervisor, the DON, or Resident #1 outside on the back patio with ide the facility staff participated in the iffed as a wanderer/elopement risk. intenance Supervisor on [DATE] on the first, that are assigned to residents reviewed here in any distress, only confused. CNA F iate interviewed were enceked on at least every two hours. CNA sk/wanderer the staff must report to intenance Supervisor, Central Supply on the investigation on [DATE] during the first shi
F 0226 Level of harm - Immediate jeopardy Residents Affected - Some	resident property. ***NOTE- TERMS IN BRACKET Based on observation, interview a that prohibit neglect for one (Res: On [DATE], CNA E failed to noti her room after finding her outside On [DATE], CNA F failed to noti	istreatment, neglect, or abuse of residents or TS HAVE BEEN EDITED TO PROTECT CON nd record review, the facility failed to impleme ident #1) of one residents reviewed for neglect t fy Resident #1 's charge nurse, the DON and A without staff supervision. fy Resident #1 's charge nurse, the DON and A g her outside on a patio without staff supervisio	VFIDENTIALITY** nt their written policies and procedures to provide adequate supervision. dministrator when she returned the resident to dministrator when she returned the resident to
	when EMS arrived. Her death wa These failures resulted in a past no		
FORM CMS-2567(02-99)	Event ID: YL1011	Facility ID: 455463	If continuation sheet

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED:10/25/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER 455463	(X2) MULTIPLE CONSTRU A. BUILDING B. WING	ICTION	(X3) DATE SURVEY COMPLETED 06/22/2016
NAME OF PROVIDER OF SU FHE MEADOWS HEALTH	IPPLIER AND REHABILITATION CENT	ER	STREET ADDRESS, CITY, ST 8383 MEADOW RD	LATE, ZIP
For information on the nursing	home's plan to correct this deficient	cy, please contact the nursing l	DALLAS, TX 75231 nome or the state survey agency.	
(X4) ID PREFIX TAG	· ·	DEFICIENCIES (EACH DEFI	CIENCY MUST BE PRECEDED I	BY FULL REGULATORY
F 0226	(continued from page 2) This failure could affect three resi	dents, who were identified by	the facility as wanderers and/or and	elopement risk by
Level of harm - Immediate jeopardy		d Neglect Prohibition Policy,	revised [DATE], revealed, Each res	
Residents Affected - Some	property. The Resident Elopement Policy, r	evised [DATE] reflected, It is	ijuries of unknown origin, and misa the responsibility of all personnel to	o report any resident
	document the occurrence. Review of the facility's Resident F resident to the facility's Resident of of Nursing); Contact the attending order [REDACTED]. records (D) safety measures to the Quality As necessary); and Update the reside Review of the facility 's Testing t door monitors and signaling devi internal batteries will be replaced will perform daily checks to verif	Elopement Policy regarding mi or of Nursing and the Administ g physician, report findings ann rector of Nursing); Investigate isurance and Performance Imp nt's care plan with interventic he Wanderguard System, revis ces in the alarm system will be at least once a year or when th y the operation of the signaling	ed February 2010 revealed, regular conducted to verify the integrity of the red light does not come on when g device using a signaling device te	vealed, Upon return of the for injuries (Director low the physician's recommendations regarding r the Safety Team Committee (as testing of Wanderguard f the system. The pressed. Nursing staff ster. Nursing staff
	conducted in the resident 's recor monitors weekly. Review of the facility 's Abuse an	d. Maintenance will inspect an ad Neglect Prohibition Policy, 1	bands immediately if damaged and d test each door monitor and test th revised [DATE], revealed, Each res	he range of the door sident has the right to be
	property. Resident #1 's Closed Record refl Review of Resident #1's Care Plan diagnosed as an elopement risk/w function of safety monitoring dev revealed Resident #1 used a whee	ected on the Admission Recorn h, dated [DATE], revealed Res- anderer with impaired cognitic ice every shift, identify patterr chair for mobility.	juries of unknown origin, and misa d that she admitted to the facility or ident #1 was diagnosed with [RED on on [DATE]. Interventions includ of wandering, and intervene as ap E] revealed a score of 16. A score of	n [DATE] at the age of 59. ACTED]. Resident #1 was led check placement and propriate. Care Plan
	#1 was mobile with a device, resi	stant to long term care placeme ent, and had shown a history o	ent, was cognitively impaired show f elopement within the past six mo	n by decreased safety
	Review of the facility 's Progress at around 0620 laying down in he nurse met the resident on the hall and administered her morning me breakfast. Resident was again see by this nurse. Around 1258 reside locate the resident within the unit active search began all staff was i on her back and facing up with al to elicit response from the patient assessment. I alerted one of the st alternated performing CPR until to on the site by the paramedics. Th on-call for the primary physician Review of the facility 's Incident/	Note, dated [DATE] and comp r bed during the initial mornin way by her room and I redirect dications as scheduled and per n by this nurse around 0945 be int was noted missing from het and nearby lounge but residen nitiated both within and outsid I extremities extended on the p both verbally and touch by sh aff to call 911 and get the crash he paramedics arrived to the so is nurse called the family and r was also notified about the inc Accident Report, dated [DATE itate.pronounced dead by the	E], revealed Resident was found out paramedics upon arrival. Incident/A	ft. Around 0720 this checked her blood sugar lee dining room to get her me the resident was seen rking on the floor tried to le was activated and e resident laying down it around 1315. I tried e, no pulse upon se and one of nurses sident was pronounced dead he incident. Np tside the building
	Review of the facility's Investigati resident lying on a pavement with felt. CPR initiated. EMS called. S	ion Follow-Up, dated [DATE] her wheelchair besides her no kin assessed with [REDACTE	and completed by the DON, reveal tresponding to call. Lie (sic) face i D]. CPR continued until EMS arriv n re-directed several times when sh	up. Assessed pulse not ved. Resident had a wander
	hour routine checks. The DON re transitioned to long term care on building. The facility would mon a history of elopement prior to the wear a Wanderguard bracelet. On sidewalk beside the facility. Resid paramedics arrived, continued CI	vealed that when Resident #1 a the second floor. Resident #1 d itor her wandering and re-direc i ncident. Resident #1 did not [DATE], Resident #1 was fou dent #1 did not have any vital s R, and then pronounced Resid v if an autopsy was performed	N revealed Resident #1 was identifi admitted to the facility she resided lid have cognition deficits and wou t her back up upstairs to her room. attempt to exit the building in the p ind lying on her back, with her whe signs and the staff called 911 and in ent #1 expired at 1:30 PM. The fan or the cause of death. There were r	on the first floor and Id wander throughout the Resident #1 did not have bast. Resident #1 did elchair beside her, on the uitiated CPR. The nily and medical examiner were
	The DON stated further the facilit AM on [DATE], by nursing staff noted Resident #1 was not in her the sidewalk around 1:00 PM. Du that had occurred in the days just Resident #1 outside of the facility staff re-directed the resident back incident to their immediate super the following incident occurred in a separate occurrence. There was Wanderguard alarm due to the tw revealed the facility has two addii In an interview on [DATE] at 9:30 facility investigation residents rev regarding the time. All staff prese in order to turn the Wanderguard denied entering the code in order conducted with residents tast stat	y began an investigation on [D on the second floor near her re room. The staff initiated the m uring the investigation, she bec- prior to the incident on [DATT of the hearing the Wanderguar inside to her room on the secc- visor, Director of Nursing, or A t the morning on [DATE] prior no documentation regarding the of acility employees not report tional residents that have been 0 AM, the ADON A stated the vealed that they did hear the alt ent during the incident involvin alarm off. Residents that were to to turn the alarm off when Res ed they heard the alarms go off	ATE] which revealed Resident #1 nom. Around 12:30 PM, the staff w issing resident protocol and found is ame aware of additional incidents of E]. Two facility staff revealed that the d alarm sound on two separate occi- nd floor. Both staff members denied Administrator. The first incident occi- to Resident #1 being reported mis- te first two instances of Resident #- ing finding Resident #1 outside of identified as a wanderer/elopement Wanderguard alarm was working of g Resident #1 missing on [DATE], present at the door that Resident #- ident #1 exited the building. Follow f were not consistent with previous	ere passing lunch trays and Resident #1 outside on of elopement by Resident #1 hey witnessed asions. Both facility ed reporting either uurred on [DATE] and sing later the same day on I setting off the the facility. The DON risk. porrectly on [DATE]. During the pecific details of denied entering the code I exited the building v up interviews were interviews. The
	building. Review of CNA E's Witness State to 7:30PM when the alarms went	ment, dated [DATE] revealed,	s in-serviced on being secure with On [DATE] I saw (Resident #1) de c) I saw her and I re-directed her an	ownstairs between the hours of 7
	around 7:00 PM due to the Wand the Wanderguard alarm from an e	erguard alarm going off. CNA exit door on the first floor. CNA	ealed she found Resident #1 outside E revealed she was downstairs on a A E stated she immediately brought 1 was in her wheelchair and did no	her lunch break when she heard t Resident #1 inside the

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED:10/25/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2016
NAME OF PROVIDER OF SU THE MEADOWS HEALTH 4	455463 PPLIER AND REHABILITATION CENT		
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state surve	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE P MATION)	RECEDED BY FULL REGULATORY
F 0226 Level of harm - Immediate jeopardy	Administrator about finding Resid regarding the incident. CNA E sta supervisor, DON, or Administrato	ilding. CNA E stated she did not notify her immediat dent #1 outside of the facility. CNA E reported she di tted she was verbally counseled about the facility pol or immediately after finding a resident leaving the fac	id not inform any facility staff licy to report to her immediate
Residents Affected - Some	that wander guard (sic) system way (Resident #1) was sitting out on t 2-central. Interview with CNA F on [DATE when she was about to clock in. She im another resident. CNA F disabled room. CNA F revealed Resident 4 stated she did not report finding F Administrator. CNA F stated she room. CNA F did not directly inff to report to her immediate superv attempting to leave the facility. Review of all staff in-service train residents, and elopement risks we in-service training, including staf Facility staff from all shifts were Review of the Facility Elopement second, and third shifts. A total o with wandering/elopement risk wo Observations throughout the inves In an interview with CNA C on [I wear a wander guard around their Residents that are identified as wi C revealed that if a resident is fot their supervisor immediately. Individual Interviews were condu Coordinator, CNA A, CNA B, CI revealed they had participate the facility's elopement and missi the correct residents that were wa able to identify behaviors to idem On [DATE], the DON was notifie through [DATE] at a scope of pat non-compliance prior to the begin	Drill revealed drills were conducted by the Maintena f 59 facility staff participated in the drills. Staff that a ere included in the drill. tigation on [DATE] revealed Wanderguard alarms w DATE] at 9:50 AM, CNA C revealed residents that ar wrist. CNA C revealed Resident #1 was a wanderer anderers or an elopement risk are supposed to be chee end outside that is identified as an elopement risk/war cted with facility staff from various shifts (Maintenan NA C, CNA D, MA A, and ADON B) throughout the ment and missing resident training during orientation ed in elopement risks as identified by the facility. J ify wanderers or exit-seeking behavior. d of an Immediate Jeopardy at Past Noncompliance F tern with actual harm. The facility had implemented	sical Therapist) was outside noticed ack upstairs to .unit on aderguard system going off around 7:00 AM t #1 outside on the back patio with e facility and back upstairs to her any distress, only confused. CNA F appervisor, the DON, or dent #1 from downstairs back to her counseled about the facility policy ag a resident leaving the facility or l door codes secure, missing facility staff participated in the as a wanderer/elopement risk. and compared to residents vere functioning properly. te identified as a wanderer/elopement risk and needed constant re-directing. cked on at least every two hours. CNA nderer the staff must report to nce Supervisor, Central Supply investigation on [DATE] during the first shift, and routine in-services. Interviewed provide sufficient knowledge of D, MA A, and ADON B were able to identify Direct care staff interviewed were had been identified. The IJ occurred [DATE] actions that corrected the
F 0323 Level of harm - Immediate jeopardy Residents Affected - Some	supervision to prevent avoidabl **NOTE-TERMS IN BRACKET Based on observation, interview a to prevent avoidable accidents for On [DATE], CNA E failed to noti her room after finding her outside On [DATE], CNA F failed to noti	S HAVE BEEN EDITED TO PROTECT CONFIDE nd record review, the facility failed to ensure each rer one (Resident #1) of three residents reviewed for su fy Resident #1's charge nurse, the DON and Adminis	ENTIALITY** sident received adequate supervision pervision.) strator when she returned the resident to
	On [DATE] at 1:10 PM, Resident when EMS arrived. Her death wa These failures resulted in a past no pattern with actual harm. The fac the investigation. This failure could affect three resi placing them at risk injury, harm Findings included: Resident #1 's Closed Record refl Review of Resident #1's Care Plan diagnosed as an elopement risk/w function of safety monitoring dev revealed Resident #1 used a whee Resident #1 's Elopement Risk A: #1 was mobile with a device, resi awareness, disturbances in judgm higher was considered at risk for Review of the facility's Progress N at around 0620 laying down in he nurse met the resident on the hall and administered her morning me breakfast. Resident within the unit active search began all staff was i on her back and facing up with al to elicit response from the patient assessment. I alerted one of the sta alternated performing CPR until on the site by the paramedics. Th on-call for the primary physician Review of the facility's Incident/ unresponsive, attempted to resusc no physical injuries were noted tt Review of the facility's Investigati resident lying on a pavement with	#1 was found outside on the pavement face down wis spronounced at 1:30 PM. incompliance Immediate Jeopardy that occurred on [lity had implemented actions that corrected the non-of- dents, who were identified by the facility as wandered or death. ected on the Admission Record that she admitted to t h, dated [DATE], revealed Resident #1 was diagnosed anderer with impaired cognition on [DATE]. Interve ice every shift, identify pattern of wandering, and int ichair for mobility. ssessment conducted on [DATE] revealed a score of stant to long term care placement, was cognitively in ent, and had shown a history of elopement within the	DATE] through [DATE] at a scope of compliance prior to the beginning of rs and/or an elopement risk by the facility on [DATE] at the age of 59. d with [REDACTED]. Resident #1 was intions included check placement and tervene as appropriate. Care Plan 16. A score of 16 reflects that Residents apaired shown by decreased safety e past six months. A score of 12 or led, Resident was observed by this nurse ing of the shift. Around 0720 this oom where I checked her blood sugar hen left for the dining room to get her was the last time the resident was seen the CNA working on the floor tried to lopement code was activated and urse found the resident laying down he building at around 1315. I tried s no response, no pulse upon PR. This nurse and one of nurses tes later. Resident was pronounced dead tify them of the incident. Np vas found outside the building al. Incident/Accident Report revealed DON, revealed, At 1310 (1:10 PM) found ie (sic) face up. Assessed pulse not

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 10/25/2016 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 06/22/2016
	455463		
NAME OF PROVIDER OF SU	JPPLIER AND REHABILITATION CENT	STREET ADDRESS, CIT ER 8383 MEADOW RD	Y, STATE, ZIP
		DALLAS, TX 75231	
(X4) ID PREFIX TAG		cy, please contact the nursing home or the state survey agenc DEFICIENCIES (EACH DEFICIENCY MUST BE PRECED	•
F 0323	OR LSC IDENTIFYING INFORMATION) (continued from page 4)		
Level of harm - Immediate		sure from eloping. She had been re-directed several times who	en she attempted to elope in
jeopardy Residents Affected - Some	hour routine checks. The DON re transitioned to long term care on building. The facility would mon	[DATE] at 11:45 AM, the DON revealed Resident #1 was ide vealed that when Resident #1 admitted to the facility she resi the second floor. Resident #1 did have cognition deficits and itor her wandering and re-direct her back up upstairs to her ro e incident. Resident #1 did not attempt to exit the building in	ded on the first floor and would wander throughout the bom. Resident #1 did not have
	wear a Wanderguard bracelet. On [DATE], Resident #1 was found lying on her back by the DON, with her wheelchair beside her, on the sidewalk beside the facility. Resident #1 did not have any vital signs and the staff called 911 and initiated CPR. The paramedics arrived, continued CPR, and then pronounced Resident #1 expired at 1:30 PM. The family and medical examiner were notified. The facility did not know if an autopsy was performed or the cause of death. There were no signs of injuries, bruises, or scrapes when Resident #1 was found.		
	The DON stated further the facilit	y began an investigation on [DATE] which revealed Residen on the second floor near her room. Around 12:30 PM, the sta	t #1 was last seen around 10:00 ff were passing lunch trays and
	the sidewalk around 1:00 PM. Du	room. The staff initiated the missing resident protocol and fo ring the investigation, she became aware of additional incide	nts of elopement by Resident #1
	Resident #1 outside of the facility	prior to the incident on [DATE]. Two facility staff revealed t after hearing the Wanderguard alarm sound on two separate	occasions. Both facility
	incident to their immediate super-	inside to her room on the second floor. Both staff members of visor, Director of Nursing, or Administrator. The first inciden	at occurred on [DATE] and
	a separate occurrence.	n the morning on [DATE] prior to Resident #1 being reported) AM, the ADON A stated the Wanderguard alarm was work	<u> </u>
	facility investigation residents rev	Pand, the ADON A stated the wanderguard afarm was work realed that they did hear the alarm go off, but could not provi- ent during the incident involving Resident #1 missing on [DA	de specific details of
	in order to turn the Wanderguard	alarm off. Residents that were present at the door that Reside to turn the alarm off when Resident #1 exited the building. F	ent #1 exited the building
	facility would then have to chang	ed they heard the alarms go off were not consistent with prev e all the codes. The facility was in-serviced on being secure v	
		ment, dated [DATE] revealed, On [DATE] I saw (Resident # off I quickly ran and check (sic) I saw her and I re-directed h	
	around 7:00 PM due to the Wand the Wanderguard alarm from an e building and re-directed her back being re-directed back into the bu Administrator about finding Resi	E on [DATE] at 1:40 PM revealed she found Resident #1 ou erguard alarm going off. CNA E revealed she was downstairs xit door on the first floor. CNA E stated she immediately bro to the second floor. Resident #1 was in her wheelchair and d ilding. CNA E stated she did not notify her immediate supery dent #1 outside of the facility. CNA E reported she did not in ited she was verbally counseled about the facility policy to re	s on her lunch break when she heard ught Resident #1 inside the id not provide any resistance visor, THE DON, or form any facility staff
	supervisor, DON, or Administrato facility. Review of CNA F's Witness State	or immediately after finding a resident leaving the facility or a ment, dated [DATE] revealed, On [DATE]th 2016 when I cld as going off on back patio went to see if any PT (Physical Th	attempting to leave the ocked in at ,[DATE] AM notice (sic)
	2-central. Interview with CNA F on [DATE]	he back patio with another Pt. (patient) re-directed .back upst] at 1:52 PM revealed on [DATE], she heard the Wanderguar	
	another resident. CNA F disabled room. CNA F revealed Resident i stated she did not report finding F Administrator. CNA F stated she room. CNA F did not directly infi to report to her immediate superv	mediately went to check the door and found Resident #1 outs the door alarm and re-directed Resident #1 inside the facility #1 was in her wheelchair and did not appear to be in any distr Resident #1 outside of the facility to her immediate supervision announced to the second floor that she brought Resident #1 f orm any facility staff. CNA F stated she was verbally counsel isor, DON, or Administrator immediately after finding a resident	/ and back upstairs to her ess, only confused. CNA F r, the DON, or rom downstairs back to her led about the facility policy
		Elopement Policy, revised [DATE] revealed, It is the responsi leave the premises, or suspected of being missing, to the Dire	
	Review of the facility's Resident F resident to the facility, the Director of Nursing); Contact the attending order [REDACTED]. records (Di	Elopement Policy regarding missing residents, revised [DATH or of Nursing and the Administrator should: Examine the resi g physician, report findings and conditions of the resident, an rector of Nursing); Investigate how the resident eloped and n surance and Performance Improvement (QAPI) Committee a	dent for injuries (Director d follow the physician's nake recommendations regarding
	necessary); and Update the reside Review of the facility 's Testing t door monitors and signaling devii internal batteries will be replaced will perform daily checks to verif will check the wristbands for tear	nt 's care plan with interventions for elopement prevention. he Wanderguard System, revised February 2010 revealed, re- ces in the alarm system will be conducted to verify the integri at least once a year or when the red light does not come on w y the operation of the signaling device using a signaling devi s or other damage and replace bands immediately if damaged d. Maintenance will inspect and test each door monitor and tt	gular testing of Wanderguard ity of the system. The when pressed. Nursing staff ce tester. Nursing staff and record the test was
	monitors weekly. Review of all staff in-service train residents, and elopement risks we	ing revealed in-services regarding keeping doors and door co reconducted on [DATE] by ADON A. A total of 98 facility f that directly work with residents that are identified as a wan	des secure, missing staff participated in the
	Facility staff from all shifts were Review of the Facility Elopement second, and third shifts. A total of with wandering/elopement risk w	present and received the training. Drill revealed drills were conducted by the Maintenance Sup f 59 facility staff participated in the drills. Staff that are assign ere included in the drill.	ervisor on [DATE] on the first, ned to residents
	In an interview with CNA C on [I wear a wander guard around their Residents that are identified as wa C revealed that if a resident is fou	stigation on [DATE] revealed Wanderguard alarms were funct DATE] at 9:50 AM, CNA C revealed residents that are identif wrist. CNA C revealed Resident #1 was a wanderer and need anderers or an elopement risk are supposed to be checked on and outside that is identified as an elopement risk/wanderer th	ied as a wanderer/elopement risk ded constant re-directing. at least every two hours. CNA
	Coordinator, CNA A, CNA B, Cl revealed they had received eloper staff revealed they had participate the facility's elopement and missi the correct residents that were wa	cted with facility staff from various shifts (Maintenance Sup NA C, CNA D, MA A, and ADON B) throughout the investig nent and missing resident training during orientation and rou ed in elopement drills. Interviewed staff were able to provide ng resident policies. CNA A, CNA B, CNA C, CNA D, MA nderers/elopement risks as identified by the facility. Direct ca	gation on [DATE] during the first shif tine in-services. Interviewed sufficient knowledge of A, and ADON B were able to identify
	On [DATE], the DON was notifie	ify wanderers or exit-seeking behavior. d of an Immediate Jeopardy at Past Noncompliance had been tern with actual harm. The facility had implemented actions t	

TEMENT OF ICIENCIES D PLAN OF RECTION (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 06/22/2016 10 ENNTIFICATION NUMBER NUMBER B. WING 06/22/2016 11 E OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 12 MEADOWS HEALTH AND REHABILITATION CENTER B383 MEADOW RD DALLAS, TX 75231 06/22/2016 13 Information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0323 vevel of harm - Immediate pardy (continued from page 5) non-compliance prior to the beginning of the investigation. On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	EPARTMENT OF HEALTH ENTERS FOR MEDICARE &	AND HUMAN SERVICES & MEDICAID SERVICES		PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391
455463 Ite OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP MEADOWS HEALTH AND REHABILITATION CENTER 8383 MEADOW RD DALLAS, TX 75231 information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0323 evel of harm - Immediate pardy (continued from page 5) non-compliance prior to the beginning of the investigation. On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	TATEMENT OF EFICIENCIES ND PLAN OF OPDECTION	/ CLIA IDENNTIFICATION	A. BUILDING	(X3) DATE SURVEY COMPLETED
IE OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP MEADOWS HEALTH AND REHABILITATION CENTER 8383 MEADOW RD DALLAS, TX 75231 information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 8000000000000000000000000000000000000	JKRECTION			
DALLAS, TX 75231 information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0323 (continued from page 5) non-compliance prior to the beginning of the investigation. On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	ME OF PROVIDER OF SUI		STREET A	ADDRESS, CITY, STATE, ZIP
information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. 4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0323 (continued from page 5) non-compliance prior to the beginning of the investigation. vel of harm - Immediate On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	E MEADOWS HEALTH A	AND REHABILITATION CENT	ER 8383 MEA	DOW RD
OR LSC IDENTIFYING INFORMATION) 0323 (continued from page 5) non-compliance prior to the beginning of the investigation. opardy On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	r information on the nursing	home's plan to correct this deficien		
0323 (continued from page 5) non-compliance prior to the beginning of the investigation. evel of harm - Immediate On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	X4) ID PREFIX TAG	SUMMARY STATEMENT OF I	EFICIENCIES (EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY
evel of harm - Immediate prior to the beginning of the investigation. On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.	7 0323		MATION)	
On [DATE] the DON provided the resident roster with three residents identified as wanderers/elopement risks.		non-compliance prior to the begin	ning of the investigation.	
	jeopardy	On [DATE] the DON provided the	e resident roster with three residents identified	d as wanderers/elopement risks.
	Residents Affected - Some			