STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455463	A. BUILDING _____ B. WING _____	**06/22/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEADOWS HEALTH AND REHABILITATION CENTER	**8383 MEADOW RD DALLAS, TX 75231**

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 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their policies and procedures that prohibit neglect for one (Resident #1) of one residents reviewed for neglect to provide adequate supervision. On [DATE], CNA E failed to notify Resident #1 ' s charge nurse, the DON and Administrator when she returned the resident to her room after finding her outside without staff supervision. On [DATE], CNA F failed to notify Resident #1 ' s charge nurse, the DON and Administrator when she returned the resident to her second floor room after finding her outside on a patio without staff supervision. On [DATE] at 1:10 PM, Resident #1 was found outside on the pavement face down with no pulse. CPR was initiated and continued when EMS arrived. Her death was pronounced at 1:30 PM. These failures resulted in a past noncompliance Immediate Jeopardy that occurred on [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the non-compliance prior to the beginning of the investigation. This failure could affect three residents, who were identified by the facility as wanderers and/or an elopement risk by placing them at risk injury, harm or death. Findings included: The Resident Elopement Policy, revised [DATE] reflected, It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Director of Nursing and the Administrator and to document the occurrence. Review of the facility's Resident Elopement Policy regarding missing residents, revised [DATE] revealed, Upon return of the resident to the facility, the Director of Nursing and the Administrator should: Examine the resident for injuries (Director of Nursing); Contact the attending physician, report findings and conditions of the resident, and follow the physician's order [REDACTED]. records (Director of Nursing); Investigate how the resident eloped and make recommendations regarding safety measures to the Quality Assurance and Performance Improvement (QAPI) Committee and or the Safety Team Committee (as necessary); and Update the resident ' s care plan with interventions for elopement prevention. Review of the facility ' s Testing the Wanderguard System, revised February 2010 revealed, regular testing of Wanderguard door monitors and signaling devices in the alarm system will be conducted to verify the integrity of the system. The internal batteries will be replaced at least once a year or when the red light does not come on when pressed. Nursing staff will perform daily checks to verify the operation of the signaling device using a signaling device tester. Nursing staff will check the wristbands for tears or other damage and replace bands immediately if damaged and record the test was conducted in the resident ' s record. Maintenance will inspect and test each door monitor and test the range of the door monitors weekly. Review of the facility ' s Abuse and Neglect Prohibition Policy, revised [DATE], revealed, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property. Resident #1 ' s Closed Record reflected on the Admission Record that she admitted to the facility on [DATE] at the age of 59. Review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 was diagnosed with [REDACTED]. Resident #1 was diagnosed as an elopement risk/wanderer with impaired cognition on [DATE]. Interventions included check placement and function of safety monitoring device every shift, identify pattern of wandering, and intervene as appropriate. Care Plan revealed Resident #1 used a wheelchair for mobility. Resident #1 ' s Elopement Risk Assessment conducted on [DATE] revealed a score of 16. A score of 16 reflects that Residents #1 was mobile with a device, resistant to long term care placement, was cognitively impaired shown by decreased safety awareness, disturbances in judgment, and had shown a history of elopement within the past six months. A score of 12 or higher was considered at risk for elopement. Review of the facility ' s Progress Note, dated [DATE] and completed by LVN A, revealed, Resident was observed by this nurse at around 0620 laying down in her bed during the initial morning rounds at the beginning of the shift. Around 0720 this nurse met the resident on the hallway by her room and I redirected her back into the room where I checked her blood sugar and administered her morning medications as scheduled and per MAR. The resident then left for the dining room to get her breakfast. Resident was again seen by this nurse around 0945 back in her room. This was the last time the resident was seen by this nurse. Around 1258 resident was noted missing from her room, this nurse and the CNA working on the floor tried to locate the resident within the unit and nearby lounge but resident could not be seen. Elopement code was activated and active search began all staff was initiated both within and outside the building. This nurse found the resident laying down on her back and facing up with all extremities extended on the pavement just outside the building at around 1315. I tried to elicit response from the patient both verbally and touch by shaking her but there was no response, no pulse upon assessment. I alerted one of the staff to call 911and get the crash cart while I started CPR. This nurse and one of nurses alternated performing CPR until the paramedics arrived to the scene about seven minutes later. Resident was pronounced dead on the site by the paramedics. This nurse called the family and responsible party to notify them of the incident. Np on-call for the primary physician was also notified about the incident. Review of the facility ' s Incident/Accident Report, dated [DATE], revealed Resident was found outside the building unresponsive, attempted to resuscitate .pronounced dead by the paramedics upon arrival. Incident/Accident Report revealed no physical injuries were noted to resident. Family and physician were notified. Review of the facility's Investigation Follow-Up, dated [DATE] and completed by the DON, revealed, At 1310 (1:10 PM) found resident lying on a pavement with her wheelchair besides her not responding to call. Lie (sic) face up. Assessed pulse not felt. CPR initiated. EMS called. Skin assessed with [REDACTED]. CPR continued until EMS arrived. Resident had a wander guard (sic) as a preventative measure from eloping. She had been re-directed several times when she attempted to elope in the past. In an interview with the DON on [DATE] at 11:45 AM, the DON revealed Resident #1 was identified as a wanderer and was on two hour routine checks. The DON revealed that when Resident #1 admitted to the facility she resided on the first floor and transitioned to long term care on the second floor. Resident #1 did have cognition deficits and would wander throughout the building. The facility would monitor her wandering and re-direct her back up upstairs to her room. Resident #1 did not have a history of elopement prior to the incident. Resident #1 did not attempt to exit the building in the past. Resident #1 did

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.

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) wear a Wanderguard bracelet. On [DATE], Resident #1 was found lying on her back, 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 facility began an investigation on [DATE] which revealed Resident #1 was last seen around 10:00 AM on [DATE], by nursing staff on the second floor near her room. Around 12:30 PM, the staff were passing lunch trays and noted Resident #1 was not in her room. The staff initiated the missing resident protocol and found Resident #1 outside on the sidewalk around 1:00 PM. During the investigation, she became aware of additional incidents of elopement by Resident #1 that had occurred in the days just prior to the incident on [DATE]. Two facility staff revealed that they witnessed Resident #1 outside of the facility after hearing the Wanderguard alarm sound on two separate occasions. Both facility staff re-directed the resident back inside to her room on the second floor. Both staff members denied reporting either incident to their immediate supervisor, Director of Nursing, or Administrator. The first incident occurred on [DATE] and the following incident occurred in the morning on [DATE] prior to Resident #1 being reported missing later the same day on a separate occurrence. There was no documentation regarding the first two instances of Resident #1 setting off the Wanderguard alarm due to the two facility employees not reporting finding Resident #1 outside of the facility. The DON revealed the facility has two additional residents that have been identified as a wanderer/elopement risk. In an interview on [DATE] at 9:30 AM, the ADON A stated the Wanderguard alarm was working correctly on [DATE]. During the facility investigation residents revealed that they did hear the alarm go off, but could not provide specific details of regarding the time. All staff present during the incident involving Resident #1 missing on [DATE], denied entering the code in order to turn the Wanderguard alarm off. Residents that were present at the door that Resident #1 exited the building denied entering the code in order to turn the alarm off when Resident #1 exited the building. Follow up interviews were conducted with residents that stated they heard the alarms go off were not consistent with previous interviews. The facility would then have to change all the codes. The facility was in-serviced on being secure with the codes to exit the building. Review of CNA E's Witness Statement, dated [DATE] revealed, On [DATE] I saw (Resident #1) downstairs between the hours of 7 to 7:30PM when the alarms went off I quickly ran and check (sic) I saw her and I re-directed her and she followed me back upstairs. Interview by telephone with CNA E on [DATE] at 1:40 PM revealed she found Resident #1 outside of the facility on [DATE] around 7:00 PM due to the Wanderguard alarm going off. CNA E revealed she was downstairs on her lunch break when she heard the Wanderguard alarm from an exit door on the first floor. CNA E stated she immediately brought Resident #1 inside the building and re-directed her back to the second floor. Resident #1 was in her wheelchair and did not provide any resistance being re-directed back into the building. CNA E stated she did not notify her immediate supervisor, THE DON, or Administrator about finding Resident #1 outside of the facility. CNA E reported she did not inform any facility staff regarding the incident. CNA E stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of CNA F's Witness Statement, dated [DATE] revealed, On [DATE]th 2016 when I clocked in at ,[DATE] AM notice (sic) that wander guard (sic) system was going off on back patio went to see if any PT (Physical Therapist) was outside noticed (Resident #1) was sitting out on the back patio with another Pt. (patient) re-directed .back upstairs to .unit on 2-central. Interview with CNA F on [DATE] at 1:52 PM revealed on [DATE], she heard the Wanderguard system going off around 7:00 AM when she was about to clock in. She immediately went to check the door and found Resident #1 outside on the back patio with another resident. CNA F disabled the door alarm and re-directed Resident #1 inside the facility and back upstairs to her room. CNA F revealed Resident #1 was in her wheelchair and did not appear to be in any distress, only confused. CNA F stated she did not report finding Resident #1 outside of the facility to her immediate supervisor, the DON, or Administrator. CNA F stated she announced to the second floor that she brought Resident #1 from downstairs back to her room. CNA F did not directly inform any facility staff. CNA F stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of all staff in-service training revealed in-services regarding keeping doors and door codes secure, missing residents, and elopement risks were conducted on [DATE] by ADON A. A total of 98 facility staff participated in the in-service training, including staff that directly work with residents that are identified as a wanderer/elopement risk. Facility staff from all shifts were present and received the training. Review of the Facility Elopement Drill revealed drills were conducted by the Maintenance Supervisor on [DATE] on the first, second, and third shifts. A total of 59 facility staff participated in the drills. Staff that are assigned to residents with wandering/elopement risk were included in the drill. Observations throughout the investigation on [DATE] revealed Wanderguard alarms were functioning properly. In an interview with CNA C on [DATE] at 9:50 AM, CNA C revealed residents that are identified as a wanderer/elopement risk wear a wander guard around their wrist. CNA C revealed Resident #1 was a wanderer and needed constant re-directing. Residents that are identified as wanderers or an elopement risk are supposed to be checked on at least every two hours. CNA C revealed that if a resident is found outside that is identified as an elopement risk/wanderer the staff must report to their supervisor immediately. Individual Interviews were conducted with facility staff from various shifts (Maintenance Supervisor, Central Supply Coordinator, CNA A, CNA B, CNA C, CNA D, MA A, and ADON B) throughout the investigation on [DATE] during the first shift, revealed they had received elopement and missing resident training during orientation and routine in-services. Interviewed staff revealed they had participated in elopement drills. Interviewed staff were able to provide sufficient knowledge of the facility's elopement and missing resident policies. CNA A, CNA B, CNA C, CNA D, MA A, and ADON B were able to identify the correct residents that were wanderers/elopement risks as identified by the facility. Direct care staff interviewed were able to identify behaviors to identify wanderers or exit-seeking behavior. On [DATE], the DON was notified of an Immediate Jeopardy at Past Noncompliance had been identified. The IJ occurred [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the 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.
F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their written policies and procedures that prohibit neglect for one (Resident #1) of one residents reviewed for neglect to provide adequate supervision. On [DATE], CNA E failed to notify Resident #1 ' s charge nurse, the DON and Administrator when she returned the resident to her room after finding her outside without staff supervision. On [DATE], CNA F failed to notify Resident #1 ' s charge nurse, the DON and Administrator when she returned the resident to her second floor room after finding her outside on a patio without staff supervision. On [DATE] at 1:10 PM, Resident #1 was found outside on the pavement face down with no pulse. CPR was initiated and continued when EMS arrived. Her death was pronounced at 1:30 PM. These failures resulted in a past noncompliance Immediate Jeopardy that occurred on [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the non-compliance prior to the beginning of the investigation.

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) This failure could affect three residents, who were identified by the facility as wanderers and/or an elopement risk by placing them at risk injury, harm or death. Findings included: Review of the facility ' s Abuse and Neglect Prohibition Policy, revised [DATE], revealed, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property. The Resident Elopement Policy, revised [DATE] reflected, It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Director of Nursing and the Administrator and to document the occurrence. Review of the facility's Resident Elopement Policy regarding missing residents, revised [DATE] revealed, Upon return of the resident to the facility, the Director of Nursing and the Administrator should: Examine the resident for injuries (Director of Nursing); Contact the attending physician, report findings and conditions of the resident, and follow the physician's order [REDACTED]. records (Director of Nursing); Investigate how the resident eloped and make recommendations regarding safety measures to the Quality Assurance and Performance Improvement (QAPI) Committee and or the Safety Team Committee (as necessary); and Update the resident ' s care plan with interventions for elopement prevention. Review of the facility ' s Testing the Wanderguard System, revised February 2010 revealed, regular testing of Wanderguard door monitors and signaling devices in the alarm system will be conducted to verify the integrity of the system. The internal batteries will be replaced at least once a year or when the red light does not come on when pressed. Nursing staff will perform daily checks to verify the operation of the signaling device using a signaling device tester. Nursing staff will check the wristbands for tears or other damage and replace bands immediately if damaged and record the test was conducted in the resident ' s record. Maintenance will inspect and test each door monitor and test the range of the door monitors weekly. Review of the facility ' s Abuse and Neglect Prohibition Policy, revised [DATE], revealed, Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, injuries of unknown origin, and misappropriation of property. Resident #1 ' s Closed Record reflected on the Admission Record that she admitted to the facility on [DATE] at the age of 59. Review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 was diagnosed with [REDACTED]. Resident #1 was diagnosed as an elopement risk/wanderer with impaired cognition on [DATE]. Interventions included check placement and function of safety monitoring device every shift, identify pattern of wandering, and intervene as appropriate. Care Plan revealed Resident #1 used a wheelchair for mobility. Resident #1 ' S Elopement Risk Assessment conducted on [DATE] revealed a score of 16. A score of 16 reflects that Residents #1 was mobile with a device, resistant to long term care placement, was cognitively impaired shown by decreased safety awareness, disturbances in judgment, and had shown a history of elopement within the past six months. A score of 12 or higher was considered at risk for elopement. Review of the facility ' s Progress Note, dated [DATE] and completed by LVN A, revealed, Resident was observed by this nurse at around 0620 laying down in her bed during the initial morning rounds at the beginning of the shift. Around 0720 this nurse met the resident on the hallway by her room and I redirected her back into the room where I checked her blood sugar and administered her morning medications as scheduled and per MAR. The resident then left for the dining room to get her breakfast. Resident was again seen by this nurse around 0945 back in her room. This was the last time the resident was seen by this nurse. Around 1258 resident was noted missing from her room, this nurse and the CNA working on the floor tried to locate the resident within the unit and nearby lounge but resident could not be seen. Elopement code was activated and active search began all staff was initiated both within and outside the building. This nurse found the resident laying down on her back and facing up with all extremities extended on the pavement just outside the building at around 1315. I tried to elicit response from the patient both verbally and touch by shaking her but there was no response, no pulse upon assessment. I alerted one of the staff to call 911and get the crash cart while I started CPR. This nurse and one of nurses alternated performing CPR until the paramedics arrived to the scene about seven minutes later. Resident was pronounced dead on the site by the paramedics. This nurse called the family and responsible party to notify them of the incident. Np on-call for the primary physician was also notified about the incident. Review of the facility ' s Incident/Accident Report, dated [DATE], revealed Resident was found outside the building unresponsive, attempted to resuscitate .pronounced dead by the paramedics upon arrival. Incident/Accident Report revealed no physical injuries were noted to resident. Family and physician were notified. Review of the facility's Investigation Follow-Up, dated [DATE] and completed by the DON, revealed, At 1310 (1:10 PM) found resident lying on a pavement with her wheelchair besides her not responding to call. Lie (sic) face up. Assessed pulse not felt. CPR initiated. EMS called. Skin assessed with [REDACTED]. CPR continued until EMS arrived. Resident had a wander guard (sic) as a preventative measure from eloping. She had been re-directed several times when she attempted to elope in the past. In an interview with the DON on [DATE] at 11:45 AM, the DON revealed Resident #1 was identified as a wanderer and was on two hour routine checks. The DON revealed that when Resident #1 admitted to the facility she resided on the first floor and transitioned to long term care on the second floor. Resident #1 did have cognition deficits and would wander throughout the building. The facility would monitor her wandering and re-direct her back up upstairs to her room. Resident #1 did not have a history of elopement prior to the incident. Resident #1 did not attempt to exit the building in the past. Resident #1 did wear a Wanderguard bracelet. On [DATE], Resident #1 was found lying on her back, 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 facility began an investigation on [DATE] which revealed Resident #1 was last seen around 10:00 AM on [DATE], by nursing staff on the second floor near her room. Around 12:30 PM, the staff were passing lunch trays and noted Resident #1 was not in her room. The staff initiated the missing resident protocol and found Resident #1 outside on the sidewalk around 1:00 PM. During the investigation, she became aware of additional incidents of elopement by Resident #1 that had occurred in the days just prior to the incident on [DATE]. Two facility staff revealed that they witnessed Resident #1 outside of the facility after hearing the Wanderguard alarm sound on two separate occasions. Both facility staff re-directed the resident back inside to her room on the second floor. Both staff members denied reporting either incident to their immediate supervisor, Director of Nursing, or Administrator. The first incident occurred on [DATE] and the following incident occurred in the morning on [DATE] prior to Resident #1 being reported missing later the same day on a separate occurrence. There was no documentation regarding the first two instances of Resident #1 setting off the Wanderguard alarm due to the two facility employees not reporting finding Resident #1 outside of the facility. The DON revealed the facility has two additional residents that have been identified as a wanderer/elopement risk. In an interview on [DATE] at 9:30 AM, the ADON A stated the Wanderguard alarm was working correctly on [DATE]. During the facility investigation residents revealed that they did hear the alarm go off, but could not provide specific details of regarding the time. All staff present during the incident involving Resident #1 missing on [DATE], denied entering the code in order to turn the Wanderguard alarm off. Residents that were present at the door that Resident #1 exited the building denied entering the code in order to turn the alarm off when Resident #1 exited the building. Follow up interviews were conducted with residents that stated they heard the alarms go off were not consistent with previous interviews. The facility would then have to change all the codes. The facility was in-serviced on being secure with the codes to exit the building. Review of CNA E's Witness Statement, dated [DATE] revealed, On [DATE] I saw (Resident #1) downstairs between the hours of 7 to 7:30PM when the alarms went off I quickly ran and check (sic) I saw her and I re-directed her and she followed me back upstairs. Interview by telephone with CNA E on [DATE] at 1:40 PM revealed she found Resident #1 outside of the facility on [DATE] around 7:00 PM due to the Wanderguard alarm going off. CNA E revealed she was downstairs on her lunch break when she heard the Wanderguard alarm from an exit door on the first floor. CNA E stated she immediately brought Resident #1 inside the building and re-directed her back to the second floor. Resident #1 was in her wheelchair and did not provide any resistance

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F 0226 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) being re-directed back into the building. CNA E stated she did not notify her immediate supervisor, THE DON, or Administrator about finding Resident #1 outside of the facility. CNA E reported she did not inform any facility staff regarding the incident. CNA E stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of CNA F's Witness Statement, dated [DATE] revealed, On [DATE]th 2016 when I clocked in at ,[DATE] AM notice (sic) that wander guard (sic) system was going off on back patio went to see if any PT (Physical Therapist) was outside noticed (Resident #1) was sitting out on the back patio with another Pt. (patient) re-directed .back upstairs to .unit on 2-central. Interview with CNA F on [DATE] at 1:52 PM revealed on [DATE], she heard the Wanderguard system going off around 7:00 AM when she was about to clock in. She immediately went to check the door and found Resident #1 outside on the back patio with another resident. CNA F disabled the door alarm and re-directed Resident #1 inside the facility and back upstairs to her room. CNA F revealed Resident #1 was in her wheelchair and did not appear to be in any distress, only confused. CNA F stated she did not report finding Resident #1 outside of the facility to her immediate supervisor, the DON, or Administrator. CNA F stated she announced to the second floor that she brought Resident #1 from downstairs back to her room. CNA F did not directly inform any facility staff. CNA F stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of all staff in-service training revealed in-services regarding keeping doors and door codes secure, missing residents, and elopement risks were conducted on [DATE] by ADON A. A total of 98 facility staff participated in the in-service training, including staff that directly work with residents that are identified as a wanderer/elopement risk. Facility staff from all shifts were present and received the training. Review of the Facility Elopement Drill revealed drills were conducted by the Maintenance Supervisor on [DATE] on the first, second, and third shifts. A total of 59 facility staff participated in the drills. Staff that are assigned to residents with wandering/elopement risk were included in the drill. Observations throughout the investigation on [DATE] revealed Wanderguard alarms were functioning properly. In an interview with CNA C on [DATE] at 9:50 AM, CNA C revealed residents that are identified as a wanderer/elopement risk wear a wander guard around their wrist. CNA C revealed Resident #1 was a wanderer and needed constant re-directing. Residents that are identified as wanderers or an elopement risk are supposed to be checked on at least every two hours. CNA C revealed that if a resident is found outside that is identified as an elopement risk/wanderer the staff must report to their supervisor immediately. Individual Interviews were conducted with facility staff from various shifts (Maintenance Supervisor, Central Supply Coordinator, CNA A, CNA B, CNA C, CNA D, MA A, and ADON B) throughout the investigation on [DATE] during the first shift, revealed they had received elopement and missing resident training during orientation and routine in-services. Interviewed staff revealed they had participated in elopement drills. Interviewed staff were able to provide sufficient knowledge of the facility's elopement and missing resident policies. CNA A, CNA B, CNA C, CNA D, MA A, and ADON B were able to identify the correct residents that were wanderers/elopement risks as identified by the facility. Direct care staff interviewed were able to identify behaviors to identify wanderers or exit-seeking behavior. On [DATE], the DON was notified of an Immediate Jeopardy at Past Noncompliance had been identified. The IJ occurred [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the 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.
F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent avoidable accidents for one (Resident #1) of three residents reviewed for supervision. On [DATE], CNA E failed to notify Resident #1's charge nurse, the DON and Administrator when she returned the resident to her room after finding her outside without staff supervision. On [DATE], CNA F failed to notify Resident #1's charge nurse, the DON and Administrator when she returned the resident to her second floor room after finding her outside on a patio without staff supervision. On [DATE] at 1:10 PM, Resident #1 was found outside on the pavement face down with no pulse. CPR was initiated and continued when EMS arrived. Her death was pronounced at 1:30 PM. These failures resulted in a past noncompliance Immediate Jeopardy that occurred on [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the non-compliance prior to the beginning of the investigation. This failure could affect three residents, who were identified by the facility as wanderers and/or an elopement risk by placing them at risk injury, harm or death. Findings included: Resident #1 ' s Closed Record reflected on the Admission Record that she admitted to the facility on [DATE] at the age of 59. Review of Resident #1's Care Plan, dated [DATE], revealed Resident #1 was diagnosed with [REDACTED]. Resident #1 was diagnosed as an elopement risk/wanderer with impaired cognition on [DATE]. Interventions included check placement and function of safety monitoring device every shift, identify pattern of wandering, and intervene as appropriate. Care Plan revealed Resident #1 used a wheelchair for mobility. Resident #1 ' s Elopement Risk Assessment conducted on [DATE] revealed a score of 16. A score of 16 reflects that Residents #1 was mobile with a device, resistant to long term care placement, was cognitively impaired shown by decreased safety awareness, disturbances in judgment, and had shown a history of elopement within the past six months. A score of 12 or higher was considered at risk for elopement. Review of the facility's Progress Note, dated [DATE] and completed by LVN A, revealed, Resident was observed by this nurse at around 0620 laying down in her bed during the initial morning rounds at the beginning of the shift. Around 0720 this nurse met the resident on the hallway by her room and I redirected her back into the room where I checked her blood sugar and administered her morning medications as scheduled and per MAR. The resident then left for the dining room to get her breakfast. Resident was again seen by this nurse around 0945 back in her room. This was the last time the resident was seen by this nurse. Around 1258 resident was noted missing from her room, this nurse and the CNA working on the floor tried to locate the resident within the unit and nearby lounge but resident could not be seen. Elopement code was activated and active search began all staff was initiated both within and outside the building. This nurse found the resident laying down on her back and facing up with all extremities extended on the pavement just outside the building at around 1315. I tried to elicit response from the patient both verbally and touch by shaking her but there was no response, no pulse upon assessment. I alerted one of the staff to call 911and get the crash cart while I started CPR. This nurse and one of nurses alternated performing CPR until the paramedics arrived to the scene about seven minutes later. Resident was pronounced dead on the site by the paramedics. This nurse called the family and responsible party to notify them of the incident. Np on-call for the primary physician was also notified about the incident. Review of the facility ' s Incident/Accident Report, dated [DATE], revealed Resident was found outside the building unresponsive, attempted to resuscitate .pronounced dead by the paramedics upon arrival. Incident/Accident Report revealed no physical injuries were noted to resident. Family and physician were notified. Review of the facility's Investigation Follow-Up, dated [DATE] and completed by the DON, revealed, At 1310 (1:10 PM) found resident lying on a pavement with her wheelchair besides her not responding to call. Lie (sic) face up. Assessed pulse not felt. CPR initiated. EMS called. Skin assessed with [REDACTED]. CPR continued until EMS arrived. Resident had a wander

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	455463	A. BUILDING _____ B. WING _____	06/22/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE MEADOWS HEALTH AND REHABILITATION CENTER	8383 MEADOW RD DALLAS, TX 75231

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0323 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) guard (sic) as a preventative measure from eloping. She had been re-directed several times when she attempted to elope in the past. In an interview with the DON on [DATE] at 11:45 AM, the DON revealed Resident #1 was identified as a wanderer and was on two hour routine checks. The DON revealed that when Resident #1 admitted to the facility she resided on the first floor and transitioned to long term care on the second floor. Resident #1 did have cognition deficits and would wander throughout the building. The facility would monitor her wandering and re-direct her back up upstairs to her room. Resident #1 did not have a history of elopement prior to the incident. Resident #1 did not attempt to exit the building in the past. Resident #1 did 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 facility began an investigation on [DATE] which revealed Resident #1 was last seen around 10:00 AM on [DATE], by nursing staff on the second floor near her room. Around 12:30 PM, the staff were passing lunch trays and noted Resident #1 was not in her room. The staff initiated the missing resident protocol and found Resident #1 outside on the sidewalk around 1:00 PM. During the investigation, she became aware of additional incidents of elopement by Resident #1 that had occurred in the days just prior to the incident on [DATE]. Two facility staff revealed that they witnessed Resident #1 outside of the facility after hearing the Wanderguard alarm sound on two separate occasions. Both facility staff re-directed the resident back inside to her room on the second floor. Both staff members denied reporting either incident to their immediate supervisor, Director of Nursing, or Administrator. The first incident occurred on [DATE] and the following incident occurred in the morning on [DATE] prior to Resident #1 being reported missing later the same day on a separate occurrence. In an interview on [DATE] at 9:30 AM, the ADON A stated the Wanderguard alarm was working correctly on [DATE]. During the facility investigation residents revealed that they did hear the alarm go off, but could not provide specific details of regarding the time. All staff present during the incident involving Resident #1 missing on [DATE], denied entering the code in order to turn the Wanderguard alarm off. Residents that were present at the door that Resident #1 exited the building denied entering the code in order to turn the alarm off when Resident #1 exited the building. Follow up interviews were conducted with residents that stated they heard the alarms go off were not consistent with previous interviews. The facility would then have to change all the codes. The facility was in-serviced on being secure with the codes to exit the building. Review of CNA E's Witness Statement, dated [DATE] revealed, On [DATE] I saw (Resident #1) downstairs between the hours of 7 to 7:30PM when the alarms went off I quickly ran and check (sic) I saw her and I re-directed her and she followed me back upstairs. Interview by telephone with CNA E on [DATE] at 1:40 PM revealed she found Resident #1 outside of the facility on [DATE] around 7:00 PM due to the Wanderguard alarm going off. CNA E revealed she was downstairs on her lunch break when she heard the Wanderguard alarm from an exit door on the first floor. CNA E stated she immediately brought Resident #1 inside the building and re-directed her back to the second floor. Resident #1 was in her wheelchair and did not provide any resistance being re-directed back into the building. CNA E stated she did not notify her immediate supervisor, THE DON, or Administrator about finding Resident #1 outside of the facility. CNA E reported she did not inform any facility staff regarding the incident. CNA E stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of CNA F's Witness Statement, dated [DATE] revealed, On [DATE]th 2016 when I clocked in at ,[DATE] AM notice (sic) that wander guard (sic) system was going off on back patio went to see if any PT (Physical Therapist) was outside noticed (Resident #1) was sitting out on the back patio with another Pt. (patient) re-directed .back upstairs to .unit on 2-central. Interview with CNA F on [DATE] at 1:52 PM revealed on [DATE], she heard the Wanderguard system going off around 7:00 AM when she was about to clock in. She immediately went to check the door and found Resident #1 outside on the back patio with another resident. CNA F disabled the door alarm and re-directed Resident #1 inside the facility and back upstairs to her room. CNA F revealed Resident #1 was in her wheelchair and did not appear to be in any distress, only confused. CNA F stated she did not report finding Resident #1 outside of the facility to her immediate supervisor, the DON, or Administrator. CNA F stated she announced to the second floor that she brought Resident #1 from downstairs back to her room. CNA F did not directly inform any facility staff. CNA F stated she was verbally counseled about the facility policy to report to her immediate supervisor, DON, or Administrator immediately after finding a resident leaving the facility or attempting to leave the facility. Review of the facility's Resident Elopement Policy, revised [DATE] revealed, It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the Director of Nursing and the Administrator and to document the occurrence. Review of the facility's Resident Elopement Policy regarding missing residents, revised [DATE] revealed, Upon return of the resident to the facility, the Director of Nursing and the Administrator should: Examine the resident for injuries (Director of Nursing); Contact the attending physician, report findings and conditions of the resident, and follow the physician's order [REDACTED]. records (Director of Nursing); Investigate how the resident eloped and make recommendations regarding safety measures to the Quality Assurance and Performance Improvement (QAPI) Committee and or the Safety Team Committee (as necessary); and Update the resident ' s care plan with interventions for elopement prevention. Review of the facility ' s Testing the Wanderguard System, revised February 2010 revealed, regular testing of Wanderguard door monitors and signaling devices in the alarm system will be conducted to verify the integrity of the system. The internal batteries will be replaced at least once a year or when the red light does not come on when pressed. Nursing staff will perform daily checks to verify the operation of the signaling device using a signaling device tester. Nursing staff will check the wristbands for tears or other damage and replace bands immediately if damaged and record the test was conducted in the resident ' s record. Maintenance will inspect and test each door monitor and test the range of the door monitors weekly. Review of all staff in-service training revealed in-services regarding keeping doors and door codes secure, missing residents, and elopement risks were conducted on [DATE] by ADON A. A total of 98 facility staff participated in the in-service training, including staff that directly work with residents that are identified as a wanderer/elopement risk. Facility staff from all shifts were present and received the training. Review of the Facility Elopement Drill revealed drills were conducted by the Maintenance Supervisor on [DATE] on the first, second, and third shifts. A total of 59 facility staff participated in the drills. Staff that are assigned to residents with wandering/elopement risk were included in the drill. Observations throughout the investigation on [DATE] revealed Wanderguard alarms were functioning properly. In an interview with CNA C on [DATE] at 9:50 AM, CNA C revealed residents that are identified as a wanderer/elopement risk wear a wander guard around their wrist. CNA C revealed Resident #1 was a wanderer and needed constant re-directing. Residents that are identified as wanderers or an elopement risk are supposed to be checked on at least every two hours. CNA C revealed that if a resident is found outside that is identified as an elopement risk/wanderer the staff must report to their supervisor immediately. Individual Interviews were conducted with facility staff from various shifts (Maintenance Supervisor, Central Supply Coordinator, CNA A, CNA B, CNA C, CNA D, MA A, and ADON B) throughout the investigation on [DATE] during the first shift, revealed they had received elopement and missing resident training during orientation and routine in-services. Interviewed staff revealed they had participated in elopement drills. Interviewed staff were able to provide sufficient knowledge of the facility's elopement and missing resident policies. CNA A, CNA B, CNA C, CNA D, MA A, and ADON B were able to identify the correct residents that were wanderers/elopement risks as identified by the facility. Direct care staff interviewed were able to identify behaviors to identify wanderers or exit-seeking behavior. On [DATE], the DON was notified of an Immediate Jeopardy at Past Noncompliance had been identified. The IJ occurred [DATE] through [DATE] at a scope of pattern with actual harm. The facility had implemented actions that corrected the

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F 0323 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(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.