STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455748	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASHFORD HALL	**2021 SHOAF DR IRVING, TX 75061**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for one (Resident #2) of four residents reviewed for supervision. The facility failed to provide Resident #2 adequate supervision to prevent elopement after she displayed exit seeking behavior and elopement attempts. Resident #2 eloped on 03/11/20 and was found by the police. The facility did not implement any additional measures to prevent further elopements and Resident #2 eloped again on 04/07/10 and 04/10/20. An Immediate Jeopardy (IJ) was identified on 05/13/20. While the IJ was removed on 05/15/20, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. The administrator was provided the IJ Template on 05/13/20. This failure could place residents at risk of elopement, resulting in physical harm, injury, emotional distress, or even death. The findings included: Review of Resident #2's face sheet revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #2's quarterly MDS assessment, dated 02/25/20 revealed her cognitive skills were severely impaired. The resident was assessed as having wandering behaviors daily. Resident #2 required supervision with walking and transferring. The resident used no mobility devices. [DIAGNOSES REDACTED]. Review of Resident #2's Care Plan, last revised 03/15/20, revealed the resident had eloped on 03/11/20, but the Care Plan indicated the problem began on 01/02/20 due to an initial elopement attempt that was investigated. Interventions began on 01/02/20 reflecting the resident had a wanderguard and it would be checked every shift for placement, alarm system checked by maintenance every shift to ensure proper functioning, the resident's name will be posted in binder at nurses station with residents at risk of elopement, staff will be aware of Resident #2 watching the door as she was preparing to exit. A second elopement was documented on the care plan as having occurred on 03/11/20, and the available intervention listed was that Resident #2 would be placed on one-on-one observation for three days to ensure no further elopement attempts were made. There were no other elopements or interventions listed for the resident after the 03/11/20 date. Review of the facility's Event Report, dated 03/11/20 and completed by LVN D, revealed Resident #2 eloped from the building and walked all the way to the street. Police found the resident and returned her to the facility. The report indicated Resident #2 always wants to go home to see her parents. The resident's family member told the facility staff that Resident #2 would elope at any slight opportunity. According to the report, Resident #2 was last seen by the assigned staff at the nurses station when the aide went to provide care for another resident. The resident was placed on 15 minute checks. Review of the facility's Provider Investigation Report (PIR) related to Resident #2's elopement, dated 03/15/20, revealed Resident #2 was seen at the atrium doors on 03/11/20 when EMTs entered the facility with an empty stretcher to pick up a resident. The paramedics spoke with Resident #2 when they entered and then she exited the facility. The PIR summary revealed Resident #2 was found two blocks from the facility searching for her former house. According to the PIR two ladies had stopped to talk to the resident and then called 911 because they felt she was confused. The police had already been notified by the facility and were looking for the resident. Review of Resident #2's clinical record reflected a Q-15 Minute Log dated 03/11/20 with all dates and times for the first, second, and third shift filled out. There were no other available Q-15 Minute logs for the month of March 2020 or April 2020. Review of Resident #2's progress note, dated 04/07/20 and documented by LVN D, revealed Resident #2 eloped at approximately 5:00 p.m. on 04/07/20. The resident was found by a staff member on the street behind the facility. According to the progress note Resident #2 exited through the back door at station four by the TV area. Staff said they did not hear the alarm on the door sound. The alarm was tested and was found to be turned off. The note indicated the resident had been seen by another resident and was observed by a staff member who was in the parking lot. The resident was returned to the building and she continued to say she wanted to go home. Review of the facility's event report, dated 04/10/20 and created by RN A, revealed Resident #2 was located offsite at the intersection of two streets. The event report indicated Resident #2 had unsuccessful elopement attempts in the past as well as successful elopement attempts. According to the event report Resident #2 had a history of [REDACTED]. Resident #2 exhibited agitation, anxiety, and confusion when exit seeking. The resident's [DIAGNOSES REDACTED]. Notes documented in the event report revealed when staff checked Resident #2's room to provide care, the resident was not in her room. The staff checked every room and then announced a Code Purple, indicating a missing resident. Staff searched throughout the facility and outside of the facility but were unable to locate her. RN A called 911 to report Resident #2 missing and gave a description of Resident #2. After hearing the description of the resident, the police informed RN A they had found the resident at the intersection of the two streets. Later the police called and provided the address so someone from the facility could come pick up the resident. Review of Mapquest.com on 06/01/20, revealed the intersection at which Resident #2 was found following her elopement on 04/10/20 was 1.4 miles and a 34 to 35 minute walk depending on the route taken. The walk would have required the Resident #2 to cross a major busy intersection with a lane going in each direction and a median splitting the lanes. Review of the facility's Provider Investigation Report, dated 04/10/20, Resident #2 was not in her room when staff checked on her. The staff began searching and announced a Code Purple, informing staff there was a missing resident. The police were called and they told staff they had found the resident near an intersection. Review of Resident #2 progress note, dated 04/10/20 at 9:19 p.m. and documented by RN A, revealed when the staff went to Resident #2's room to change here, the resident was not in the room. According to the note, the staff checked the hallway and informed the nurse. Staff began searching every room and announced a Code Purple, which indicated a resident was missing. The note indicated RN A contacted 911 and police were notified of the missing resident. RN A was informed by the police Resident #2 had found at the intersection of two streets. CNA staff went to pick up the resident. Interview with LVN D on 05/13/20 at 2:52 p.m. revealed Resident #2 eloped twice while he was working. The first time occurred on 03/11/20. He stated the resident was standing at the door when the paramedics came in the door and she walked out the atrium door. LVN D said there was no alarm on the door so the resident could have exited without the paramedics entering the facility. LVN D said Resident #2 eloped again on 04/07/20. He said she exited the door, and a resident saw her. A staff member was in the facility's parking lot, saw the resident, and brought the resident back into the building. LVN D said the resident continued to exit seek. Interview with RA E on 05/13/20 at 3:23 p.m. revealed she was in the facility parking lot on 04/07/20 at 5:00 p.m. when she observed Resident #2 walking in the street that runs in front of the facility. RA E stated Resident #2 was near the warehouse located next to the facility. The CNA approached Resident #2 and returned her to the facility. Interview with RN A revealed Resident #2 had eloped during her shift on 04/10/20. She said the resident was very anxious and had wandered and twice before on that evening she had tried to exit the facility. RN A stated Resident #2 was taken to her room by CNA B after 7:30 p.m., but when he returned to check on Resident #2, she was not in her room. RN A stated the police were notified, and when she described the resident, the police reported they had

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) someone matching that description. The RN reported the facility did not have a Secure Unit. Interview with CNA B on 05/13/20 at 4:57 p.m. revealed he was the CNA working with Resident #2 when she eloped on 04/10/20. He said he assisted Resident #2 to bed and then returned ten minutes later to check on her, but the resident was not in the room. He said staff searched throughout the facility, and RN A called the police. He stated Resident #2 had been located by the police. CNA B stated staff were equired to check on the resident every ten minutes prior to this elopement. CNA B reported that they do not know what door she exited that evening. Interview with CNA C on 05/13/20 at 3:35 p.m. revealed she had worked with Resident #2. She said Resident #2 often cried in the evening and it the resident's crying and exit seeking worsened. CNA C said she was working the evening of 04/10/20 when Resident #2 eloped. She said when the nurse called the police, she was informed that the police officers were with the resident. CNA C said she went to pick up the resident from a residential area where the resident was waiting with the police. She said she did not remember the time, but she knew it was dark when she arrived to get the resident. CNA C said someone had turned off the door alarm and did not turn it back on so it did not sound when Resident #2 eloped. CNA C said she did not have a key to turn the alarm off and turn it back on. CNA C stated when the alarm was on if Resident #2 tried to exit the doors at the ends of the hallway, the alarm would sound. She stated that a key was necessary to turn the alarm off once it was activated and the key was also used to re-alarm the door. Interview with CNA F on 05/14/20 at 12:07 p.m. revealed she was working one time when the resident eloped, but she was not working the resident's hall. The CNA explained in the evenings Resident #2 would begin sun-downing and she would try to exit through the doors. She stated Resident #2 would become physical if staff attempted to intervene. The resident was moved to another hall because it was smaller than the hall she was living on. CNA F said Resident #2 had been this way since she admitted to the facility on [DATE]. Interview with LVN G on 05/15/20 at 11:45 a.m. revealed when the door alarms sound, a key must be inserted in the door and turned one way to turn the alarm off. She said to reactivate the alarm, the key must be turned the opposite direction, and it will beep three times indicating the alarm has been reset. She said Resident #2 had attempted to elope three or four times this morning, setting the alarms off. Review of the facility's policy for Wandering and Elopements, revised March 2019, revealed the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The administrator was informed of the immediate jeopardy on 05/13/20 and was provided with the IJ template. A Plan of Removal was also requested at that time. The following Plan of Removal was accepted 05/15/20: On 5/13/2020 at 8:30 pm Station 100-Already put in place 1 employee will be posted in the center of the station to watch the doors at both ends of the station to include the corridor door leaving station 100 for all shifts. Corridors are closed on each station due to ensuring if a resident or employee test positive for [MEDICAL CONDITION] it will not be transported to another station in our facility. Same staff work on same stations. Front lobby door monitored by the receptionists. Station 200 has no residents on the station. Station 300 has no residents on the station. Station 400 an employee will be posted in the center of the station to watch the doors at the end of the station to include the corridor door leaving station 400. Station 500 an employee will be posted in the center of the station to watch the doors at the end of the station to include the corridor door leaving station 500 going to station 400 and door going to station. The doors are closed on station 500 and to the corridor going to station 300 due to this is a quarantine unit. This was our temporary plan and ending at 2 pm on 5/14/2020 due to we have completed the training with our Hospitality aide to monitor all door every 15 mins. (See next paragraph) On 5/14/2020 at 2:00 PM going forwarded Director of Nursing / Maintenance Director already put a plan in place to provide training to our hospitality aide to round in facility every 15 mins to check all door alarms to ensure they are armed and wander guard alarms working correctly. All door alarm keys have been removed from each Charge Nurse to ensure they do not have the ability to turn off the alarms. Hospitality aide and Maintenance will be the only persons who will have the alarm keys and the wander guard alarm to check the doors. If the alarm sounds the hospitality aide will be responsible to re-set it. Charge Nurse will call a code purple and complete a head count. We will have a hospitality aide in the facility 24 hours a day, 7 days a week. This plan will remain in place until all doors have wander guard alarms installed and reprogrammed to ensure alarms reengages after 3-5 seconds. All new hires and PRN employees will be trained at the beginning of their shift. On 5/13/2020 Maintenance Supervisor already put in place training with all employees to ensure everyone is aware of how to operate door alarms. Maintenance also trained problems with the alarms to report it immediately to the maintenance department. All new hires and PRN employees will be trained at the beginning of their shift. On 5/13/2020 already put in place the Administrator has provided training to the Maintenance Department, Maintenance Assistant and the Housekeeping Supervisor to ensure the alarms are checked 2X daily to ensure door alarms are working correctly to include the wander guard doors, 7 days a week. New hires and PRN employees will be trained at the beginning of their shift. On 5/13/2020 already in place the Director of Nursing started new elopement assessments on each resident to ensure everyone who was at risk had a wander guard on. Completed on 5/14/2020. On 5/13/2020 plan already in place for all new admission will be placed on our quarantine unit for 14 days. Admitting Nurse will complete elopement assessment immediately upon admission. If the resident is at risk a wander guard will be placed on the resident and their information will be placed in our elopement binder at each station. Director of Nursing begun training on 5/13/2020. New hires and PRN employees will be trained prior to their shift starting. Monitoring of the plan of removal included the following: Reviews were made of the newly completed elopement risk assessments for all residents in the facility. Interview with HA G on 05/14/20 revealed she was responsible for checking every door, wanderguards and alarms in the facility every 15 minutes. HA G said she was the only staff with a key to the door alarms to turn off the alarms and reactivate the alarms. She said to turn the alarm off, she had to put the key in the door alarm and turn the key to turn it on, she reversed the direction of the key to reactivate the alarm. HA G stated there were green indicator lights when the alarms were off, and the alarm displayed red indicator lights when the alarm was on. Interview with HA K on 05/15/20 at 11:09 a.m. revealed she was responsible for checking all of the doors every 15 minutes to ensure the alarms were set and the wanderguards were on. HA K said they had one staff each shift that was responsible for that task. HA K stated a head count must be completed if an alarm went off. Interview with HA G on 05/15/20 at 11:09 a.m. revealed she was called in to observe Resident #2 as she had been trying to elope. HA G said she had tried to elope 05/14/20 at approximately 7:00 p.m. but the resident was stopped. Interview with CNA E on 05/15/20 at 11:40 a.m. revealed she had been trained on the new elopement protocol. The CNA explained that there was one person per shift responsible for checking the doors. That person had the key to the alarm and must turn off the alarm and reactivate the alarm. Following the alarm sounding, a head count must be completed. Interview with LVN H on 05/15/2020 at 11:45 a.m. revealed she had been trained to call a Code LVN H reported the only staff that could turn off the alarm and reactivate it was the hospitality aide who had been assigned the duty. Residents who were newly admitted must be assessed for elopement risk. She added if a resident was an elopement risk, their information was placed in a binder at the nurses' station. Resident #2 had set off the alarms that morning three or four times. Interview with CNA I on 05/15/20 at 2:46 p.m. revealed the designated hospitality aide was responsible for checking any door alarms. He said if an alarm sounded, a head count must be completed immediately. Interview with the Housekeeping/Laundry Supervisor on 05/15/20 at 2:42 p.m. revealed she had been assigned to check the alarms on the doors two times daily in addition to the 15minute checks. Interview with the Assistant Maintenance Director on 05/15/2020 at 3:10 p.m. revealed he has been assigned to check the door alarms to ensure they were activated and working two times daily. Interview with LVN J on 05/15/2020 at 2:46 p.m. revealed when a new admit entered the facility the admitting nurse must immediately complete an elopement assessment. She said if the alarm sounded, staff must the staff immediately did a head count. If someone was missing, an elopement would be announced. An Immediate Jeopardy (IJ) was identified on 05/13/20hile the IJ was removed on 05/15/20, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. The administrator was provided the IJ Template on 05/13/20.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident # 1) of 5 residents observed for infection control. LVN L failed to perform hand hygiene appropriately before beginning Resident #1's wound care. LVN L also failed to appropriately sanitize surface areas, equipment and supplies before, during and after Resident #1's wound care. This failure could place residents at risk for infection, cross contamination, and illness. Findings included: Review of Resident #1's quarterly Minimum Data Set (MDS), dated [DATE],0 revealed she was a [AGE] year-old-female admitted to the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) facility on [DATE]. Her [DIAGNOSES REDACTED]. Review of the facility's wound summary report, dated 04/11/20 to 05/11/20, revealed Resident #1 had a diabetic ulcer to her left shin Review of Resident #1's Wound physician's orders [REDACTED]. Observation on 05/12/20 at 10:30 AM revealed LVN L setting up wound care for Resident #1. LVN L did not perform hand hygiene before opening her medication cart and collecting wound care supplies. Without cleaning the top of her cart or placing a barrier down, LVN L placed all the wound care supplies on top of the cart. Without cleaning Resident #1's bedside table or placing a clean barrier down, LVN L carried all of the wound care supplies into the resident's room and placed them on top of the unsanitized bedside table. There was a glass ring observed on the bedside table and Resident #1 had just finished planting a flower bulb using her bedside table. Without performing any type of hand hygiene or cleaning her scissors, LVN L donned gloves, picked up the scissors, cut two pieces of tape, initialed and dated them then cut the visibly soiled dressing off of Resident #1's left foot/ankle and placed the contaminated scissors back on the bedside table. LVN L with the same gloves on, then picked up the wound cleanser bottle and began to spray it on the old soiled dressing on Resident #1's ankle. LVN L removed the old dressing, placed the wound cleanser bottle on the floor, and without performing hand hygiene LVN L changed her gloves. LVN L then picked up the wound cleanser bottle from the floor, sprayed the wound cleanser onto the wound bed, cleaned with a gauze 4X4, dried, and then placed the wound cleanser back on the floor. Without performing hand hygiene or changing her gloves, LVN L opened the package of calcium alginate, then placed [MEDICATION NAME] gel in the wound bed. LVN L picked up the contaminated scissors, and without cleaning/sanitizing them, cut the calcium alginate to the size of the wound bed, placed it in the wound bed, covered it with a 4X4 gauze and wrapped Resident #1's ankle/foot with a roll of bandage and taped it. LVN L picked up the wound cleanser bottle off the floor and placed it on Resident #1's bedside table, picked up the trash, washed her hands, picked up the contaminated scissors, wound cleanser bottle, bag of trash, and took them to her medication cart, threw the trash away and placed the scissors and wound cleanser bottle on top of her medication cart. In an interview with LVN L on 05/12/20 at 10:40 AM she stated she had forgotten to wash her hands before starting wound care with Resident #1 She also stated she did not wash the table top or the top of her medication cart before placing the wound care supplies on them. LVN L stated she should have cleaned her scissors before she started the procedure, after cutting the old bandage off and when she had finished the procedure. LVN L also stated she should have washed her hands when changing from dirty to clean, should not have placed the wound cleanser on the table after it was on the floor, and the contaminated scissors should not have been placed on the bedside table. In an interview with ADON B (who observed LVN L conducting wound care) on 05/12/20 at 10:45 AM she stated she expected the nurse to clean the top of their cart before they put supplies on it or at least put a barrier down. ADON B stated LVN L also should have washed her hands before she started, should have cleaned the bedside table before putting supplies down, and should have placed them on a barrier. She stated LVN L should have cleaned her scissors before and after cutting the soiled bandage off and before placing them on top of her cart. ADON B said LVN L should have washed her hands between dirty to clean and should not have placed the wound cleanser bottle on the floor, then on the table, and then to her cart. In an interview with the DON on 05/12/20 at 4:30 PM she stated she and ADON B in-serviced LVN L and watched her re-do the dressing change on the same resident. She also said LVN L had been a nurse for 5 years, and hand hygiene and setting up a clean field should be second nature . Review of the facility's policy and procedure, Infection Control Guidelines for all Nursing Procedures, dated August 2012, reflected the following: 3. Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or nonantimicrobial soap and water under the following conditions: a. Before and after direct contact with residents; c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; d. After removing gloves; It further reflected: 4. .If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: a. Before and after direct contact with residents; . e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care; . h. After handling used dressings, contaminated equipment, etc.; . j. After removing gloves. Review of the facility's policy and procedure, Dressings, Dry/Clean, dated September 2013, reflected the following: Steps in the Procedure 1. Clean bedside stand. Establish clean field. 2. Place the clean equipment on the clean field 5. Wash and dry hands thoroughly. 6. Put on clean gloves. Loosen tape and remove soiled dressing. 7. Pull glove over dressing and discard 8. Wash and dry your hands thoroughly. 9. Open dry, clean dressing . 10. Label tape or dressing .Place on clean field. 11. Using clean technique, open other products . 12. Wash and dry your hands thoroughly 22. Clean the bedside stand.