STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELKHART OAKS CARE CENTER	214 JONES RD ELKHART, TX 75839

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **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 adequate supervision to prevent accidents was provided for 1 of 1 resident reviewed for accident (Resident #3). The facility did not implement effective interventions to prevent an elopement for Resident #3 who had a history of [REDACTED]. The facility did not have all alarms on the doors turned on, resulting in Resident #3 eloping without staff knowledge from the facility on 7/24/20. Resident #3 was missing for at least one hour before he was found outside at 11:50 p.m. in his wheelchair, stuck in the mud, and drenched in sweat. This was determined to be past non-compliance that existed from 7/24/20 and was corrected on 7/28/20 due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk for injury and elopement. Findings included: Physician orders [REDACTED].#3 was a [AGE] year-old male, admitted [DATE], and had [DIAGNOSES REDACTED]. The most recent Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #3 had severe cognitive impairment. Resident #3 was independent with locomotion on and off the unit, required limited assistance with eating, toileting, and personal hygiene, required extensive assistance with bathing and dressing and had wandering episodes 1-3 times. An Event Report dated 12/31/2019 at 4:46 a.m. indicated Resident #3 successfully eloped in the past, no interventions were taken, and no interventions were necessary. Nurse documentation indicated Resident #3 went down hall 1 and opened the back door sounding the alarm in an attempt to leave the facility. When asked where he was going, he said he was leaving. It was noted that Resident #3 was fairly easy to redirect resident at this time. The report indicated Resident #3 did manage to get half of his wheelchair outside of the exit door. An evaluation note on the report indicated Resident #3 was evaluated for the need for placement on the secured unit. During an interview on 8/4/2020 at 10:00 a.m., the Social Worker said Resident #3 went to the doors and attempted to exit the facility occasionally and was easily redirected. The Social Worker said she was not sure if Resident #3 had been evaluated for the secured unit because he was easily redirected. During an interview on 7/31/2020 at 9:45 a.m., the administrator said Resident #3 had a TBI ([MEDICAL CONDITION]) from a previous car accident. She said Resident #3 He has attempted to elope maybe twice. She said she did not want to move Resident #3 to the secured unit, as wheeling around the facility was all he did, and she did not want to take that away from him. The administrator said Resident #3 would not fit in well on their small unit and would have to be moved to a bigger unit. A care plan initiated 1/14/19 indicated Resident #3 wandered throughout the facility and would open the exit doors. The care plan interventions included re-direct him as needed. He knows where his room is and will usually easily go to his room instead of other resident' room or outside. This care plan was updated on 7/27/20 to reflect a new intervention of will assess for new alarms on exit doors. An Event Report dated 7/24/2020 at 11:50 p.m. indicated Resident #3 was found behind the laundry building at 11:50 p.m. The report indicated Resident #3 had a history of [REDACTED]. A resident progress note dated 7/25/2020 at 12:05 a.m., indicated Resident #3 was not in his room when LVN K made rounds to check on the residents. The note indicated all staff assisted in searching for Resident #3 inside the facility for approximately 1 hour. Resident #3 was found outside behind the laundry building at approximately 11:50 p.m. Resident #3 was sitting in his wheelchair, which was stuck in the mud. The progress note indicated LVN K helped the resident out of the mud and back inside the building. LVN K then assessed Resident #3, and he was drenched in sweat, with no injuries or pain noted. During an interview on 8/4/2020 at 9:15 a.m., Resident #3 said he had no recollection of the evening he went outside the facility and got his wheelchair stuck in the mud. He said he enjoyed wheeling around the facility. During an interview on 8/3/2020 at 10:30 p.m., LVN K said she was assigned to Resident #3 on 7/24/20 when he was missing and found outside. She said she was making rounds after receiving report at 10:00 p.m. and saw Resident #3 was not in his room. She said she finished making her rounds because she thought he went to the dining room to drink coffee, as he frequently did. She said once she completed her rounds at approximately 10:40 p.m., she saw Resident #3 was not in the dining room. LVN K said she thought it was about 10:40 p.m. when she realized Resident #3 was missing. She said she and CNAs L and M spent an hour inside the facility searching for Resident #3. LVN K said when Resident #3 was not found inside, LVN K went outside to look for the resident. LVN K said, she saw Resident # 3 was sitting in his wheelchair and had his leg raised, and the resident said, I'm stuck. LVN K said she pulled Resident #3's chair out of the mud and assisted him back into the facility. She said she assessed him from head to toe. She said the resident was sweating, but had no visible injuries. LVN K said she did not hear any alarms go off while Resident #3 was missing. She was not aware of Resident #3 having any previous elopement attempts. LVN K said Resident #3 often told the staff he wanted to go home, and he wanted to get in his truck, which was not at the facility. LVN K said she had previously mentioned to someone that Resident #3 needed to be screened for the secured unit, but nothing was ever done. LVN K did not recall who she mentioned this to During an interview on 8/4/2020 at 9:15 a.m., CNA L said on 7/24/2020, LVN K asked her for help looking for Resident #3. She did not recall the time LVN K came to her to ask her for help. CNA L said Resident #3 wandered around the facility in his wheelchair and in the dining room. CNA L said she did not remember Resident #3 eloping from the facility prior to this incident CNA L said CNA M helped the resident bathe and changed his clothes after the elopement incident. Said she could not remember what time he was last seen in his room, or what time he went missing. During an interview on 8/4/2020 at 9:33 a.m. CNA M said on 7/24/20 she thought she was the one who noticed Resident #3 was not in his room, but she did not recall what time that was. She said her, CNA L, and LVN K looked in all the rooms and the bathrooms. She said CNA L and LVN K went outside and found the resident. She said Resident #3 seemed fine when he came back inside. Said she helped the resident bathe and changed his clothes after the elopement incident. CNA M said she was not sure what door Resident #3 exited. She said Resident #3 had set the door alarms off before a couple of times and tried to get out of the facility, but she was not aware of the resident eloping prior to this incident. Said she could not remember what time he was last seen in his room, or what time he went missing. During an observation on 8/3/20 at 10:45 a.m., the back door in the dining room (the door the facility suspected Resident #1 eloped from) lead to an uneven cemented area with numerous cracks. The area led to a short gravel road which had to be crossed to get to the laundry area which was approximately 50 yards from the facility. The area around the laundry had dirt for the covering with small patches of grass. During a telephone interview on 8/17/20 at 3:22 p.m., the maintenance director said the laundry room was approximately 50 yards from the dining room door. During an interview on 7/31/2020 at 9:45 a.m., the administrator said Resident #3 eloped from the facility on 7/24/20 and was missing for approximately an hour. The administrator said Resident #3 was moved to Hall 3 on 8/2/2020 after he wandered onto hall 3 (a unit designated for quarantined residents due to possible COVID exposure). The administrator said alarms are on all the units to notify staff of residents leaving. She said the one in the dining room was found to have been shut off after Resident #3's elopement, but no one knew who shut the alarm off or how long it had been shut off. The administrator said the LVN working was not sure of the time Resident #3 was last seen in his room, and

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) the CNA thought it was around 9:45 p.m. The administrator did not specify which CNA gave him that timeframe. The administrator said Resident #3 was found around midnight. She said the resident's wheelchair was stuck in the mud by the laundry facility. She said this will be going to the Quality Assurance for review on August 23, 2020. During an interview on 8/4/2020 at 10:00 a.m. the Social Worker said she was not aware of any previous elopement involving Resident #3. An undated Missing Resident policy stated, . the charge nurse shall be responsible for documenting the incident in the nurses notes of the resident's chart. All documentation must be concise and reflect the actual facts as they relate to the incident including: times, persons contacted condition of resident upon return to the facility, physician notification and orders, treatment indication and any other pertinent information. It was determined these failures placed Resident #3 in an Immediate Jeopardy situation from 7/24/20 to 7/28/20. The facility took the following actions to correct the non-compliance on 7/28/20: During an interview on 8/4/2020 at 3:00 p.m. The administrator said the maintenance man checked the dining room alarm on 7/28/20 and the alarm was not working. He discovered it had been shut off, but then he turned it on and it worked fine. The Record of Alarm testing dated 08/4/2020 indicated all alarms were working on the following days: 7/3, 7/9, 7/16 and 7/31/2020. Observations of facility door alarms on 8/4/2020 at 9:00 a.m. indicated the alarms on halls 1-4 and the dining room alarms were functioning. The door to hall 5 (the secured unit) would not open unless a code was put into the keypad on the wall. The facility's provider investigation report (PIR) dated 8/1/2020 indicated the incident occurred on and was reported to the state on 7/25/2020. The facility performed a prompt investigation of the incident, including obtaining statements from all available witnesses and took appropriate action to protect the residents during the investigation. The PIR indicated the administrator assessed the physical environment and noted that there were 2 different types of alarms on the hallway exit doors which made it difficult to determine which type of alarm was sounding. Maintenance staff checked the doors on 7/28/2020 and found the dining room door alarm to be disarmed. Due to the location of this door and the patterns of Resident #3 (he drinks a lot of coffee and snacks in the dining room a lot,) it is presumed this could be the door he exited from. It is the closest exit to the laundry area that may have allowed him to get to a muddy area. This resident pushes himself backwards most of the time which would reasonably conclude why he was not aware of where he was going. The PIR indicated maintenance has purchased and received the replacement alarms to allow for all alarms to operate the same and use the same key to activate, and to allow for nursing to better be able to locate the key and to have an alarm that is more user friendly. It was noted the alarm is simple to tell if it is activated or not. The PIR indicated actions taken after the facility's investigation included the following: Staff will be trained on what to do in the event of a missing resident, go on walking rounds at the end of each shift to allow for all residents to be accounted for at the end of shift changeover, trained on the new door alarms and how to ensure that they are always on. Maintenance will monitor the alarms once a day Monday-Friday and RN supervisor or designee will monitor on Saturday and Sunday. Additional barriers will be placed as a visual cue for this particular resident as he has frequent behaviors at which time he is looking for his car. An employee sign in sheet dated 7/31/2020 showed staff had training on exit seeking vs elopement, using the correct terminology, what to do when unable to locate a resident, and upon return of the resident. Staff was also trained on the new alarms, and informed that they have to stay on all the time. During an interview on 8/4/2020 at 3:45 p.m., the facility was asked for additional information at exit, no additional information was provided.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not ensure a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The facility did not maintain a clean and sanitary environment for the residents. The floors were dirty with stains, dirt, and debris on them. The privacy curtains were soiled. The vents and ceiling tiles were dirty with dust. Boxes containing biohazard waste were crushed in and were not sealed. This failure could place the residents at risk for an unsafe environment. Findings included: During an observation on 7/31/2020 between 10:15 a.m. and 10:30 a.m., resident rooms 22, 28, 23, 24, 25, 26, and 27 had dust on the ceilings, walls, and around the vents. The privacy curtains were soiled. The floors and bathrooms had stains, dirt and trash on them. The vents in rooms [ROOM NUMBERS] were dirty, and the vent in room [ROOM NUMBER] was coming out of the wall. During an observation of hall 1 on 7/31/2020 between 10:30 a.m. and 10:50 a.m., the vents in rooms [ROOM NUMBERS] were dusty, the floors in rooms [ROOM NUMBERS] had dirt and paper trash on them explain, and the toilet in room [ROOM NUMBER] did not flush. During an observation of hall 6 on 7/31/2020 between 10:50 a.m. and 11:00 a.m., the utility room's floor was dirty with stains on the floor, and a used dirty mop was in an empty bucket. During an observation in the maintenance shop on 8/3/2020 at 10:45 a.m., there were biohazard boxes which contained biohazard waste. The boxes were stacked 2 boxes high. Some of the boxes were bent and crushed in. Approximately 5 boxes were not sealed. There was a noticeable odor coming from the boxes. During an observation of the medication room on 8/3/2020 at 12:20 p.m., the floors and walls were dirty with trash and dust, there was silverware in the sink, and drinks and glasses on the counter. The vents and ceiling tiles were dirty with dust. There was a pool of water under the sink. During an interview on 8/3/2020 at 10:45 a.m., the ADON said they had run out of biohazard boxes about a week ago. During an interview on 7/31/2020 12:23 p.m., the housekeeping supervisor said rooms on the warm zone (hall designated for residents possibly exposed to COVID 19, a sometimes fatal respiratory infection) were cleaned with a peroxide multipurpose cleaner. She said she did not have any specific policies on cleaning, but used a checklist. A Housekeeping Cleaning Checklist with a revision date of 3/14/2020 indicated from 7/20/2020-8/2/2020 the main entrance, lobby, corridors, dining room, and therapy gym were cleaned twice a day. Infection Control Guidelines related to COVID-19 with a revision date of 5/12/2020 indicated the following: .disinfect high-touch surfaces and workstations at least every 1 hour in buildings with confirmed or suspected Covid-19 . During an interview on 8/4/2020 at 3:45 p.m. the facility was asked for additional information at exit, no additional information was provided.