STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455653	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYLINE NURSING CENTER	**3326 BURGOYNE DALLAS, TX 75233**

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 residents received appropriate supervision to prevent accidents for one (Resident #1) of 10 reviewed for supervision. The facility failed to provide adequate supervision to Resident #1. CNA B took Resident #1 outside for a smoke break around 10:00 AM on 07/12/20. CNA B left the resident unsupervised outside and never returned to bring Resident #1 back into the building. Resident #1 remained outside in the facility's courtyard until she was found by staff over six hours later. An Immediate Jeopardy (IJ) was identified to have occurred from 07/12/20 to 07/13/20. This was determined to be a past noncompliance IJ due to the facility having implemented actions that corrected the noncompliance prior to the investigation. This failure could place residents at risk for injury, severe injury, and even death. Findings included: Review of Resident #1's MDS assessment revealed that she was a [AGE] year-old female, who admitted to the facility on [DATE]. Resident #1's BIMS was a 03 indicating she was cognitively impaired. Her active [DIAGNOSES REDACTED]. Review of Resident's #1 Care Plan, dated 07/15/20, revealed, (Resident #1) resides in secure unit with dx: of major neurocognitive disorder with behavioral disturbances. She is high risk for elopement with history of exit seeking from previous facility. Residents does not have understanding of her current medical issues or produced interventions per psych documentation .Resident is a smoker. Will smoke at the designated smoking area .The resident was left unsupervised/unattended on smoke break. Resident will not show any sign/symptoms of feeling isolated and will feel safe and secure within the facility till the next goal date. Interventions: Assist and monitor resident for off unit activities and smoke breaks. Educate staff /employee that all residents is to be supervised during all smoke breaks. Monitor for s/s of depression, withdrawal from recent incident. Record Review of Resident #1's Smoking Assessment, dated 05/13/20, revealed the resident required at least minimal supervision while smoking. Review of the facility's report for the incident involving Resident #1, dated 07/13/20, revealed, Nursing Description: It was reported this AM that resident was taken out to smoke and left unsupervised. Resident Description: resident rambles from one subject to the next. Immediate Actions Take: Resident brought in facility and assessment completed by charge nurse with no concerns noted upon skin assessment nurse resident was in no emotional distress at this time. ADON notified by charge nurse. Injuries Observed at Time of Incident: No injuries observed at time of incident. Notes: resident denied pain or injury per charge nurse upon assessment. Resident continued to deny pain or discomfort upon DON assessment at 0900. 07/15/20: F/U on incident investigation. Upon notification of incident staff involved suspended pending investigation. Resident was assessed with [REDACTED]. Daughter notified by Administrator, DON, and Social Worker on different occasions. PA notified by DON and video call completed with resident and PA. Resident continues with no adverse effects noted. Will continue to monitor. Observations of the secured unit courtyard on 07/15/20 at 11:35 AM revealed it was a large 7ft fenced in courtyard that had lots of windows that can be viewed from residents rooms and the secured unit's activities room and there were 2 chairs outside. Record Review of CNA B's Witness Statement, dated 07/13/20, revealed, Date of Incident 07/12/20, interviewer: Administrator. Upon interview with (CNA B) whom worked 3-11 shift on 07/12/20 she states that at approximately 10:00 PM she assisted the resident (#1) to go out to smoke per residents (#1) wish due to missing earlier smoke break because of being on the phone with her family. (CNA B) states that she came back inside to finish her rounds and got busy on the hall and unfortunately forgot to let her (Resident #1) in. Interview with CNA B on 07/15/20 at 1:25 PM via the telephone revealed she had been employed at the facility for about 2 years and she worked the 3-11 PM shift. She stated on 07/12/20 there was a smoke break scheduled for 7:00 PM but Resident #1 was on the phone with her family and the staff did not want to bother the resident. She stated that the resident then came to her insisting she get her smoke break before bed. The nurse gave her the cigarette and lighter. CNA B stated she took Resident #1 out to smoke around 10:00 PM and then went back inside to finish up her rounds , leaving the resident outside. She stated that she must have gotten busy and left her outside . She said she got a call from the 11-7 AM shift stating that Resident #1 was found outdoors around 4:00 AM. She stated that she felt so bad about it. She stated that it was not hot outside when she took the resident out for her smoke break. She stated that the reason Resident #1 was forgotten was simply because she got busy. Regarding the facility's policy on smoking, she stated the staff were to stay with the resident during their smoke break. Review of RN C's Witness Statement, dated 07/13/20, revealed, Date of Incident 07/12/20, interviewer: Administrator. Upon interview with (RN C) whom works double weekends it was stated that she had given the cigarette lighter and cigarettes to CNA (B) to go with the resident (#1) to smoke. (RN C) states that she was not aware that the CNA was not outside with the resident (#1). (RN C) states she continued with her nursing duties and documentation till end of shift then gave report to the night nurse. Interview with RN C on 07/15/20 at 1:35 PM via the telephone revealed that she normally worked double weekends. She stated that she gave CNA B the cigarette and lighter because Resident #1 wanted to go out and smoke. She stated that even though it was after hours, the aide never came back to let her know the resident was still outside. She stated that she would round normally every 2 hours prior to going off shift but she did not complete her rounds, so she just assumed the resident was in her room. She stated that the facility's policy regarding smoking was that they were supervised and someone was with them all the time. She stated that she was placed on suspension after the incident. Review of LVN D's Witness Statement, dated 07/13/20, revealed, Date of Incident 07/12/20, interviewer: Administrator. Upon interview with (LVN D) for 11-7AM shift it was stated that (LVN D) had come into the facility for the 11pm-7am shift on 07/12/20 at 10:55 PM. The outgoing nurse had given report but did not mention that any resident was outside off the hall according to (LVN D). At approximately 4:30 AM (CNA E) and (LVN D) heard some noise outside and seen the residents (#1) head outside so we opened the door and brought her in. Charge nurse (LVN D) states that she did a head to toe assessment on her (Resident #1) with vitals being BP 158/78, Resp 97, Oxygen 97%, Pulse 97, Temperature 96.8. Skin Assessment revealed no injuries and resident denied any c/o pain. Charge Nurse (LVN D) states resident did not appear in any emotional distress and states resident seemed fine. I then called ADON to report incident. At 5:15 AM resident came to nurses station asking to be taken out to smoke again. She was taken out by CNA (E) and back in at 5:52 AM and she then went to her bed and slept. Interview with LVN D on 07/15/20 at 1:12 PM via the telephone revealed she worked the 11 PM -7 AM shift beginning on 07/12/20. She stated that she and the aide were the ones who found Resident #1. She stated that she saw her when she looked outside the window. LVN D stated the courtyard the resident was found in was closed in. She stated during her skin assessment she did not find any skin issues or bug bites. She stated that it was not hot outside when the resident was found and the weather was really nice out. She stated that Resident #1 did not like her bedroom door to be open during the night and would cause a scene if she was bothered at night. LVN D stated that they were supposed to round every 2 hours to check on residents . In regard to the facility's policy regarding smoking, she stated that someone was supposed to stay with the resident during their smoke break and then bring them back inside. She

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) stated that she was suspended after the incident. Review of CNA E's Witness Statement, dated 07/13/20, revealed, Date of Incident 07/12/20, interviewer: Administrator. Upon interview with (CNA E) on 11-7 shift, (CNA E) stated that at approximately 4:30 AM as she was walking down 300 hall after another resident she noticed (Resident #1) from room [ROOM NUMBER]A peeking her head up through the back door and knocking to come in. (CNA E) stated she then let her in and notified the charge nurse (LVN D). The charge nurse (LVN D) which in turn called the ADON to report the situation. (CNA E) stated she did not check on resident prior because she (Resident #1) does not like to be bothered at night. Interview with CNA E on 07/16/20 at 10:45 AM via the telephone revealed she worked the 11-7AM shift beginning on 07/12/20. She stated that she saw a head and heard some banging on the back door at around 4:30 AM and noticed that it was Resident #1. She stated that usually does not go into Resident #1's room at night because the resident does not like it. She stated that the facility's smoking policy is that smoking is supposed to be monitored. She stated that rounding is supposed to be every two hours. She stated that she was suspended after the incident. Observation and interview of Resident #1 on 07/15/20 at 11:00 AM revealed Resident #1 was ambulating independently without assistance and no issues with bug bites or injuries were observed. The resident stated that she had been living at the facility for a year, stated that she liked smoking. When asked about the incident that happened on 07/12/20 she revealed that she had been left outside. She stated that she was left outside when she was smoking. She stated that she was thinking, what's wrong with them because they could not see her. She stated that she could not see the nurses station from outside. When asked how being left outside made her feel, she did not answer. Interview with LVN F on 07/15/20 at 11:25 AM revealed following the incident involving Resident #1 the facility initiated in-services on Monday (07/13/20) regarding smoking policy, rounding, charge nurse duties, Abuse, Neglect, and Exploitation, change of shift, and a new monitoring tool for smoking. Interview with CNA G on 07/15/20 at 12:56 PM revealed that she had been working at the facility for [AGE] years. CNA G stated that she had to go to the nurses station to sign out Resident #1 in order to be taken out on a smoke break, this was something that was implemented after the incident that happened with Resident #1 on Sunday (07/12/13) night. She stated that she was in-serviced Monday (07/13/20) regarding her duties as a CNA, rounding, smoking policy, Abuse, Neglect, and Exploitation, and a new smoking monitoring tool. Interview with the ADON on 07/15/20 at 2:01 PM revealed that she was made aware of the incident involving Resident #1 being left outdoors unsupervised overnight. She stated that she had received a phone call from CNA B around 5:00 AM, she was upset, crying, and apologizing talking about what happened. She stated that she took the resident out for a smoke break and must have forgotten to bring her back indoors because she was found at 4:30 AM. She stated that she immediately contacted the Administrator and he requested the ADON to call the aides and nurses in and to wait at the facility until he arrived. She stated that Resident #1 had some memory loss, but for the most part was alert x3 maybe 4. Resident #1 did not sustain any injuries or bug bites. She stated that all the staff were immediately in-serviced on the smoking policy, a new smoking monitoring tool, nurses sign off sheet, duties of the CNA, rounding, and Abuse, Neglect, and Exploitation. Interview with the DON on 07/15/20 at 2:11 PM revealed that she came to work Monday (07/13/20) morning and the Administrator had a couple of staff members in his office. The Administrator informed her Resident #1 was left unsupervised overnight outside. She stated that she did her rounds and went to see the resident. She stated that the resident was in her room walking around, and she was making a list, but did not mention being upset about the incident that had happened that morning. She stated that she was out there for 8 hours, but that was all she would say regarding the incident. There was no distress noted, but an appointment with a doctor was set up for the resident to be seen regarding her UTI and this incident. She stated that according to the facility's policy residents were to be supervised during smoke breaks. The DON stated that she was told that CNA B had taken the resident out later than usual because the resident was on the phone with her family during the scheduled smoke break, and the resident liked to smoke before bed. She stated CNA B took the resident out to smoke and went back inside to do her bed checks, and just forgot that the resident was outside. The DON stated that the resident was a safe smoker and that was probably why CNA B left her outside alone. Her expectation was that nurses or aides or anyone was to stay with residents during their whole smoke break. Interview with the Administrator on 07/15/20 at 2:33 PM revealed he had received a call from the ADON at around 5:30 AM on 07/13/20. He stated that he immediately called her back and told her to make sure to keep the staff at the building until he arrived. He stated that he needed their statements. He stated that he arrived at the facility at around 7:00 AM. He stated that he immediately started interviewing the staff and went to visit with Resident #1. He stated that he contacted the corporate staff to make them aware of what had happened. He stated at that point he called the daughter, who had already heard about what happened from the resident, and assured her they were doing an internal investigation and all the staff were suspended until they finished it. He stated that he had spoken to the daughter letting her know her mother had an appointment to be seen by a doctor and would be seen by the facility social worker. He stated that they started in-services immediately on the smoking policy and supervision, rounding, Abuse, Neglect, and exploitation, CNA and charge nurse duties, and a new smoking monitoring tool. He stated that Resident #1 was left outside from approximately 10:00 PM Sunday (07/12/20) night to around 4:30 AM Monday (07/13/20) morning, approximately 6.5 hours. He stated that the smoking policy reflected that every smoker no matter their assessment, must have a staff member outside watching them at all times. A follow-up interview with the Administrator on 07/15/20 at 4:00 PM revealed that he had conducted a training on the smoking policy, abuse and neglect, rounding/resident supervision, change of shift, and the new smoking supervision/monitoring tool. He stated that the new smoking supervision/monitoring tool would be used and kept at the nurses' station. He stated all aides would sign out each resident that went out to smoke and all residents must be signed in when they came inside. He stated that this tool would be used for every resident that went out to smoke, and it was something that was being checked daily by management staff. The department heads were re-educating and doing in-services to ensure competencies. He stated all nurses must give a 24-hour report, and they go over the smoking assessment in morning meetings to ensure it was being completed and accurate. He stated they were ensuring that all staff were laying eyes on the residents when they were doing their rounds. He stated that they were monitoring in-services and ensuring competencies in the trainings provided. He stated that the staff involved, CNA B, RN C, LVN D, and CNA E, would all be terminated once they received the clearance from HR. A follow-up interview with the Administrator on 07/15/20 at 5:02 PM revealed that the incident happened because of human error, poor judgement on the aides' and nurses' part, and a failure to follow the policy and procedure. He stated that he in-serviced all of the secured unit staff because the staff stated that Resident #1 did not like being bothered overnight. He stated that all staff must lay eyes on the resident, but that they had to be quiet, to ensure not to wake up the resident. He stated that they will be following and ensuring competencies by auditing the smoking monitoring tool and following it in QAPI. He stated that they would be auditing the supervision tool which would be monitored by the DON and Administrator daily, at a minimum for the next 2 weeks, until they were comfortable that they were doing what was supposed to be done. He stated that QAPI would then follow the smoking tool for three months, and extend it if it needed to be extended. Review of CNA B, RN C, LVN D, and CNA E's Corrective Action Memo, dated 07/14/20, revealed the type of violation: violation of Policy or Procedure, Violation of Safety Rules, and carelessness. Action being taken: Termination. Observation of 300 hall on 07/15/20 at 10:45 AM revealed rounding being conducted. Staff were going into all residents' rooms making sure they were accounted for. Continuous observations on 07/15/20 at 1:00 PM - 5:30 PM revealed smoking breaks were being monitored by staff and supervised, no residents were being left alone and unsupervised. Observation on 07/15/20 at 10:30 PM revealed there was one nurse and one aide assigned to the secured unit. Observation of Resident #1's room revealed that she was lying in bed sleeping. Observation of the outdoor smoking area on 07/15/20 at 10:48 PM revealed that the doors were locked going outside, and there were no residents outdoors left unsupervised. Observation on 07/15/20 at 11:07 PM revealed LVN H was giving report and doing a headcount with her relief, LVN I. They were going into every bedroom and laying eyes on each resident. No issues were noted. Observation on 07/15/20 at 11:28 PM revealed that CNA J was giving report and doing a headcount with her relief, CNA K. They were going into every room and laying eyes on each resident. No issues were noted. Interview with LVN H on 07/15/20 at 10:36 PM revealed that she stated that Resident #1's last smoke break was at 8:30 PM and she was signed out and signed back in. She stated that they conducted rounding on residents every 2 hours. She stated that the last time she rounded was around 9:00 PM, and she would round again when her relief came on shift and she would give report. She stated that she was in-serviced on not leaving residents outside, headcounts, duties, smoking times and smoking policy, and smoking monitoring tool. The administration collected the monitoring tools at the end of the day and ensure it was completed and correct. She stated that she did go into Resident #1's room but she had to be very quiet when going in there. Interview with CNA J on 07/15/20 at 10:36 PM revealed that all residents during their smoking break must be supervised and not left alone. She stated that she heard a resident was left outside unsupervised overnight. She stated that residents had to be signed out when going on a smoking break. She stated that there was a smoking log at the nurses' station, and staff were to ensure they were

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) completing their rounds and a head count was done at the beginning and end of shift. She stated that rounding was completed upon arrival, every 2 hours, and as needed. She stated that she last conducted her rounds at 9:00 PM. She stated that she was in-serviced on her duties as a CNA, rounding, headcounts, smoking policy, Abuse and Neglect, and the new smoking monitoring tool. Interview with LVN I on 07/15/20 at 11:30 PM revealed that she had been working at the facility PRN for about a year. She stated that she heard about the incident that occurred with Resident #1 being left unsupervised overnight. She stated that she was in-serviced on taking a headcount, charge nurse duties, smoking monitoring tool and showed me the tool. She stated that she was in-serviced on the smoking policy, supervision and rounding, and abuse and neglect. She stated that the smoking policy reflected that they were not supposed to leave residents alone when they were smoking. She stated that she did not take residents out to smoke because she worked the overnight shift. She stated that she rounded every 2 hours, and she must lay eyes on each resident and document it. She stated that the new smoking monitoring tool reflected that you must sign residents in and out when they go out to smoke. She stated that the aide was the one who took the resident out to smoke and stayed with them. Interview with CNA K on 07/15/20 at 11:30 PM revealed that she heard about the incident with Resident #1. She stated that the facility in-serviced her on a new smoking monitoring tool. She stated that every time a resident went out for a smoke break, they must be signed out and signed back in when they were done smoking. She stated that she was also in-serviced on the duties of a CNA, smoking policy, supervision, rounding, and abuse and neglect. She stated that the smoking policy reflected that you cannot leave a resident alone when they were smoking. She stated that she had to round every 2 hours, and ensure that eyes were being laid on the resident at all times. She stated that Resident #1 did not like being rounded on, but during her in-services she was directed by her management staff to make sure they were laying eyes on every resident. Interviews with ADON, LVN F, CNA G, LVN F, CNA G, LVN H, LVN I, CNA J, and CNA K on 07/15/20 between 11:25AM to 11:30 PM revealed that staff members were able to identify smoking residents on their hall, they were able to locate the smoking notebook with the smoking auditing tool, stated the process of taking someone out to smoke and procedures done, were able to say how often residents are to be rounded on, and the duties of their job. They were aware that oversight of the program was provided by the Administrator and DON. Review of the Smoking Monitoring tool for 07/13/20, 07/14/20, and 07/15/20 revealed that the staff were signing out and signing in each resident taken out for a smoke break. Review of the facility's In-Services revealed the following in-services were conducted on 07/13/20: CNA Duties, Smoking Duties, Charge Nurse Duties, 24 hour report, Midnight Census, Abuse/Neglect, and Smoking Auditing Tool. The documentation revealed 100% of the staff received the respective trainings. The trainings went over supervision, rounding, midnight census, signing off with the change of shift nurse on the 24 hour report, smoking policy, the new smoking auditing tool, and abuse and neglect. Review of the facility policy, Smoking, dated May 2017, revealed, All residents who smoke will be supervised. Review of the facility policy, Charge Nurse Duties, dated May 2017, revealed, It is the policy of this home that the Charge nurses will follow procedure for charge nurse duties during their scheduled shift . Night Shift . 3. Makes rounds on residents, changes linen as necessary and turns residents as necessary . 7. Supervises and participates in resident rounds at least every two hours, more often if condition of resident requires. Assists with direct patient care as needed. Review of the facility policy, CNA Duties, dated May 2017, revealed, Day Tour of Duty .2. Gives a.m. care to residents assigned .23. Checks residents at the end of the shift and makes sure they are clean, dry, comfortable, have call light within reach, bed rails up (if ordered and residents are in bed) and are safe. Evening Tour of Duty .8. Turns and repositions at least every two hours bed and chair residents .15. Checks residents at the end of the shift and makes sure they are clean, dry, comfortable, have call light within reach, and bed rails up if ordered . Night Tour of Duty .2. Makes rounds on residents, checking for soiled linen, call lights and side rails (if ordered). (if side rail is used evaluate quarterly reduction) Makes necessary linen changes after washing and drying soiled residents. 3. Turns and positions for comfort every resident that is unable to turn self at least every 2 hours .5. Reports immediately to charge nurse anything unusual about residents .12. Checks residents at the end of the shift and makes sure they are clean, dry, comfortable, have call light within reach, and bed rails up, if ordered. (if side rail is used evaluate quarterly for reduction).