STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR PLACE	507 E W M WATSON BLVD DAINGERFIELD, TX 75638

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was immediately notified of a significant change of condition for 1 of 4 residents reviewed for physician notification. (Resident #1) The facility did not notify the physician when Resident #1 eloped from the facility during a global COVID 19 outbreak (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older and people of any age with serious underlying medical problems). Resident #1 was gone from the facility for more than 7 hours and flew to Portland Oregon by the time staff realized he was missing. This failure could place residents at risk for progression of disease process, delay in interventions, decreased health and decreased quality of life. Findings included: A face sheet dated 04/09/20 indicated Resident #1 was [AGE] years old, admitted on [DATE], and discharged on [DATE]. He had [DIAGNOSES REDACTED]. The face sheet indicated Resident #1 was not his own responsible party and the resident's mother had durable financial power of attorney. An elopement risk assessment dated [DATE] for Resident #1 was initiated but it was not completed and did not indicate if Resident #1 was an elopement risk. During an interview on 04/13/20 at 12:27 p.m., Resident #1's physician said Resident #1 was gravely ill before he admitted to the facility. He said Resident #1 was living in Oregon and had been diagnosed with [REDACTED].#1's mother admitted him to the facility because she was Resident #1's guardian. Physician orders [REDACTED].#1 was ordered Dascovy 200-25 mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., Tivicay 50 mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] multivitamin 18-400 mg-mcg once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] propionate nasal spray 50 mcg/actuation 2 sprays once a day between 8:00 a.m. and 10:00 a.m., and Bactrim DS 800-160 mg (antibiotic) once a day between 8:00 a.m. and 10:00 a.m. to prevent pneumocystis. A Minimum (MDS) data set [DATE] indicated Resident #1 had intact cognition, made his needs known, and understood others. He had no physical, verbal, or wandering behaviors during the review period. Resident #1 was independent with most ADLs. He was continent to bowel and bladder. A care plan last revised on 03/17/20 indicated Resident #1 had an altered immune system and staff were to follow universal precautions, monitor and report signs of infection, and provide a private room. The care plan did not address Resident #1's elopement risk. A nursing note dated 04/05/20 at 11:30 a.m. indicated staff was unable to locate Resident #1 in the facility. The note indicated the administrator, DON, 911, and resident's mother were notified but there was no indication the physician was notified. During an interview on 04/08/20 at 1:25 p.m., LVN A said she worked on 04/05/20 and went to Resident #1's room to administer his medications about 9:00 a.m. but he was not in his room. LVN A said she returned to Resident #1's room several times and could not find Resident #1. LVN A said around 11:00 a.m. or 11:30 a.m. she called Resident #1's mother and the police. She said when police called Resident #1, he said he was at the airport in Oregon. A Medication Administration Record [REDACTED]. A police report dated 04/05/20 indicated local police were dispatched at 12:11 p.m. to the facility in reference to a missing person, last seen in the facility on 04/05/20 at 3:30 a.m. by nursing staff. The report stated Resident #1's mother said she believed Resident #1 wanted to get to Oregon where his partner lived. Contact was made with Resident #1 and he said he was currently in Portland Oregon. Resident #1 said he left the facility at approximately 4:00 a.m., took a cab to the county airport, and flew to Portland Oregon. During an interview on 04/13/20 at 12:27 p.m., Resident #1's physician said Resident #1 was alert and had improved significantly since he was admitted , but he did not feel that the resident was cognitively intact enough to live independently. He said Resident #1's immune system was weakened due to his diagnoses. He said the facility did not notify him of Resident #1's elopement and until this interview, he was not aware that Resident #1 was no longer residing at the facility. He said he expected staff to check on residents more regularly. The facility's undated elopement policy indicated staff were to investigate and report all cases of missing residents. If staff discovered a resident missing from the facility they were to notify the resident's physician as well as the administrator, DON, resident's legal representative, and law enforcement.
F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their written policies and procedures to prevent neglect for 1 of 4 residents reviewed for neglect. (Resident #1) The facility did not report to the state when Resident #1, who had underlying health conditions which placed him at risk of infection, eloped from the facility during a global COVID 19 outbreak (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older and people of any age with serious underlying medical problems). Due to the outbreak, residents were to be monitored and checked every two hours for changes in their health. Resident #1 was gone from the facility for more than 7 hours and flew to Portland Oregon before staff realized he was missing. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a level of potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for neglect. Findings included: The facility's undated abuse prevention program policy indicated residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility's undated abuse investigation and reporting policy indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source were to be promptly report to local, state, and federal agencies and thoroughly investigated by facility management. Alleged abuse, neglect, exploitation or mistreatment that did not result in serious bodily injury the report were required to be reported within 24 hours. A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and discharged on [DATE]. He had [DIAGNOSES REDACTED]. The face sheet indicated Resident #1 was not his own responsible party and the resident's mother had durable financial power of attorney. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said she was Resident #1's guardian. She said Resident #1 lived in Oregon with his partner and in [DATE] she traveled to Oregon and brought Resident #1 to Texas. She said Resident #1 was confused, weighed less than 120 pounds, was diagnosed with [REDACTED].#1's partner was abusing him. She said when she admitted Resident #1 to the facility, she expressed her concerns about Resident #1 trying to get in contact with his partner and asked staff not to provide him access to phones. Resident #1's mother said she told staff that she was concerned that Resident #1 would elope from the facility and staff assured her he would not elope. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was gravely ill before he admitted to the facility. He said Resident #1 was living in Oregon and had been diagnosed with [REDACTED].#1's mother moved Resident #1 closer to her and he was admitted to the facility. He said Resident #1's mother said she was Resident #1's guardian. A nursing note dated [DATE] at 5:45 p.m. indicated Resident #1 was upset that he had to stay at the facility. The nurse notified the oncoming nurse to watch the resident for

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 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) possible elopement but noted Resident #1 made no attempt on 2:00 p.m. to 10:00 p.m. shift to elope. An elopement risk assessment dated [DATE] for Resident #1 was initiated but it was not completed and did not indicate if Resident #1 was an elopement risk. A social service note dated [DATE] indicated Resident #1 said he was admitted to the facility for panic attacks and he denied having a stroke. Resident #1 would rather be home but understood that medically he needed to be in the facility. Resident #1 was in an abusive relationship and the stroke affected his short-term memory. A citation on notice of temporary guardianship dated [DATE] and provided by Resident #1's mother, indicated she filed an application for temporary guardianship of Resident #1. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said after her son was admitted , she gave the business office manager a copy of the court ordered guardianship and the business office manager said she would scan the guardianship paperwork into Resident #1's file. During an interview on [DATE] at 11:38 a.m., the business office manager said in [DATE], Resident #1's mother told her that she was trying to obtain guardianship of Resident #1, but she did not provide guardianship paperwork. She said Resident #1's mother signed Resident #1's admission paperwork and signed it as his power of attorney. During an interview on [DATE] at 1:16 p.m., the sheriff's deputy said he went to the facility on [DATE] and served Resident #1 with guardianship papers. He said the guardianship paperwork indicated that Resident #1's mother was Resident #1's guardian. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said a few weeks after she secured the guardianship, she received a call from the facility and was told that the sheriff's department was serving the guardianship paperwork to Resident #1 and Resident #1 was upset. She said her husband went to the facility and calmed Resident #1 down. She said she spoke to Resident #1 on the phone and he understood that she had guardianship over him. A letter of temporary guardianship dated [DATE] provided by Resident #1's mother indicated she was appointed guardian of Resident #1. The temporary guardianship expired on [DATE]. On [DATE] the temporary guardianship was extended until 30 days after [DATE] due to the COVID-19 pandemic. A social service note dated [DATE] indicated Resident #1 would rather be at home (Oregon) or in his own home but was not ready medically or financially. Resident #1 said he liked it at the facility but felt somewhat controlled or restricted by his mother. Resident #1 wanted to have more freedom, but he could leave the facility with family and friends. Physician orders [REDACTED].#1 was ordered Dascovy ,[DATE] mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., Tivicay 50 mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] multivitamin ,[DATE] mg-mcg once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] propionate nasal spray 50 mcg/actuation 2 sprays once a day between 8:00 a.m. and 10:00 a.m., and Bactrim DS ,[DATE] mg (antibiotic) once a day between 8:00 a.m. and 10:00 a.m. to prevent pneumocystis. A Minimum (MDS) data set [DATE] indicated Resident #1 had intact cognition, made his needs known, and understood others. He had no physical, verbal, or wandering behaviors during the review period. Resident #1 was independent with most ADLs. He was continent of bowel and bladder. A care plan last revised on [DATE] indicated Resident #1 had an altered immune system and staff were to follow universal precautions, monitor every two hours and report signs of infection, and provide a private room. The care plan did not address Resident #1's elopement risk. A social service note dated [DATE] indicated Resident #1 wanted to reside in an apartment on his own and staff were working on a discharge plan to get him ready to reside in the community. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said the facility restricted visitors in [DATE] due to COVID-19 but Resident #1 called her during the middle of March and said staff were trying to help him to get out of the facility. Resident #1's mother said she called the facility, but the administrative staff had already left for the day and she spoke to CNA C. She said CNA C confirmed that the facility was trying to find an apartment for Resident #1. Resident #1's mother said she told staff that her son could not live independently. A nursing note dated [DATE] at 11:30 a.m. indicated staff were unable to locate Resident #1 in the facility. The administrator, DON, and the resident's mother were notified. Resident #1 was contacted by cell phone and he said he was safe, and he was headed home to Portland Oregon. Resident #1 said this was what he wanted, and this would make him happy. A Medication Administration Record [REDACTED]. A social service note dated [DATE] at 1:35 p.m. indicated Resident #1 had a desire to leave the facility and get an apartment of his own or return to Oregon and stay with his friend. The note indicated staff were working on a discharge plan and the next step was to assist Resident #1 with getting a disability check, so he would have an income. The social service note indicated that there was a discussion with Resident #1 about traveling or flying at this time and they told him he was at high risk due to COVID-19. Resident #1 left the faciity on [DATE] without staff knowledge and returned to Oregon. Resident #1 told staff his desire was to return to Oregon and he was safe. The social service note indicated Resident #1 was mentally capable of making that decision for himself. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said on [DATE] at 12:02 p.m. an unknown staff from the facility called and asked if Resident #1 was with her because he was not in the facility. She said the staff said Resident #1 was last seen around 3:30 a.m., and at 11:30 a.m. staff realized he was not in the facility. She said staff told her that they found the window in Resident #1's room open and the screen was pushed out. She said Resident #1 missed his morning medications. She said she spoke to Resident #1 a few hours later and he said he was back in Oregon. She said Resident #1 did not have money or a phone, but he somehow was able to get in contact with his partner and flew back to Oregon. During an interview on [DATE] at 2:28 p.m., LVN E said Resident #1 was alert and independent with ADLs. She said she last saw Resident #1 on [DATE] around 3:30 a.m. at the nursing station which was normal for him. She said Resident #1 was usually up during the night and would go to the conference room and call his partner on the facility's phone. LVN E said Resident #1's mother did not want Resident #1 talking to his boyfriend but there was no court order, so he could talk to anyone he wanted. She said Resident #1 would say he wanted to go home every day. She said on the morning of [DATE], Resident #1 did not say anything about wanting to go home. She said after Resident #1 was at the nursing station for a little bit then said he was tired, and he was going to his room. She said that was the last time she saw Resident #1. She said she did not hear any door alarms go off the rest of her shift. During an interview on [DATE] at 1:47 p.m., CNA F said she worked on [DATE] and she took Resident #1's breakfast tray to his room between 8:00 a.m. and 8:30 a.m. She said Resident #1 was not in his room. CNA F said it was normal for Resident #1 not to be in his room because he was independent with ADLs and smoked without supervision. She said she noticed Resident #1's window was open but did not think Resident #1's would have gone out the window. She said she did not report the window being open. She said she left Resident #1's breakfast tray in the room and left. She said if Resident #1 needed anything he would tell staff and she did not check on him like she checked on residents that required ADL assistance. During an interview on [DATE] at 1:25 p.m., LVN A said she worked on [DATE] and went to Resident #1's room to administer his medications about 9:00 a.m. She said Resident #1 was not in his room and his bed looked like it had been slept in. She said it was normal for Resident #1 to be out of his room. She said MA H said she had not seen him. LVN A said she returned to Resident #1's room about 10:30 a.m. and she thought Resident #1 was in his bathroom. She said she went back to Resident #1's room about 11:00 a.m. to 11:30 a.m. and Resident #1's bathroom door was still closed. She said she opened the bathroom door and the bathroom was empty. She said she could not find Resident #1 and she called Resident #1's mother and determined he was not with her. She said the RN supervisor called police. She said when police arrived she walked around the facility with police and noticed Resident #1's window was open and the screen was pushed out. She said when police called Resident #1, he said he was at the airport in Oregon. LVN A said Resident #1's mother told the facility that Resident #1 should not have any contact with his abuser/partner. She said Resident #1 was able to make his own decisions and she was not aware Resident #1's mother had guardianship paperwork. During an interview on [DATE] at 11:13 a.m., MA H said she worked on [DATE] but did not see Resident #1. She said Resident #1 left the facility sometime before 6:00 a.m. She said Resident #1 was alert and usually was not in his room. She said she heard that he went out the window in his room and called a cab. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was alert and had improved significantly since he was admitted , but he did not feel that the resident was cognitively intact enough to live independently. He said Resident #1's immune system was weakened due to his diagnoses. During a telephone interview on [DATE] at 12:58 p.m., Resident #1 said on [DATE] at 4:00 a.m. he left the facility. He said he walked out the door near the smoking area and a cab picked him up from the facility and took him to a local airport. He said he flew to Dallas and then flew to Oregon. He said his partner in Oregon bought his plane tickets a week prior to him leaving. He said he was able to get his medications through a resource in Portland Oregon. Resident #1 said his mother did not have guardianship over him. During an interview on [DATE] at 9:56 a.m., the administrator said they spoke to Resident #1 on [DATE] and he was safe. She said Resident #1 was his own responsible party and they had been working on discharging the resident into the community. She said Resident #1's mother said she was trying to get guardianship of Resident #1 but did not provide any paperwork to the facility. She said Resident #1 was alert and independent with his own care and staff monitored Resident #1 as staff should for independent residents. She said she did not expect LVN A to open the bathroom door when she though Resident #1 was in the bathroom. She said they reviewed video

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F 0607 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) footage and Resident #1 did not walk out any exit door because he was not seen on video. The administrator said the facility was not a prison. During an interview on [DATE] at 3:03 p.m., CNA D said Resident #1 always said he wanted to go back home to Oregon. She said he was alert and independent with most ADLs. She said she was not sure if Resident #1's mother had guardianship of Resident #1. She said Resident #1 did not have a cell phone, but he would go to the conference room and use the phone. During an interview on [DATE] at 11:20 a.m., LVN B said Resident #1 was alert and did not want to be at the facility. She said Resident #1 said he wanted to get an apartment locally but had no idea that he would leave the facility on his own. She said the last time she saw Resident #1 was the day before he left the facility and he did not say anything about leaving the facility. A police report dated [DATE] indicated local police were dispatched at 12:11 p.m. to the facility regarding a missing person. LVN A said Resident #1 was last seen in the facility on [DATE] at 3:30 a.m. by nursing staff. It is believed that Resident #1 left the facility through his room window. The report indicated Resident #1 left the facility to return to Oregon. Resident #1 was no longer considered a missing person on [DATE]. The administrator and DON were notified on [DATE] at 9:58 a.m., an IJ situation had been identified due to the above failures. The IJ template was provided to the administrator by email on [DATE] at 10:12 a.m. The facility's Plan of Removal was accepted on [DATE] at 12:08 p.m. and included: 1. All residents have the potential to be affected by this. 2. All current residents have been accounted for. 3. All current residents will have an updated elopement risk assessments completed by close of business [DATE] 4. The Administrator or designee will re-inservice all nursing staff regarding: a. Abuse/neglect b. making rounds to ensure residents are accounted every 2 hours if a CNA cannot account for a residents location they are to notify the charge nurse immediately. If the charge nurse cannot account for a resident's where about they are to notify the administrator and DON immediately. c. Licensed nurses will be re-inserviced on completing an elopement risk assessment on admission d. The MDS Coordinator will complete an elopement risk assessment annually, quarterly and with significant change. All inservicing will be completed by close of business [DATE] 5. The DON/ADON/Administrator or designee will review documentation of every 2 hour checks daily. To begin [DATE] and ongoing. The investigator confirmed the plan of removal had been implemented sufficiently to remove the IJ by: During an interview on [DATE] at 9:14 a.m., the DON said all staff were in-serviced on abuse, neglect, and ensuring residents were accounted for every 2 hours. If a CNA could not locate a resident, they would notify the charge nurse immediately. If the charge nurse could not locate the resident, they would notify the administrator and DON immediately. She said licensed nurses were in-serviced on completing elopement assessments on admission. She said all residents were assessed for elopement risk on [DATE]. She said she was reviewing the documentation that staff were visually accounting for residents every 2 hours. During interviews on [DATE], 6 CNAs and 1 MA (6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m.) said they were in-serviced on abuse, neglect, and elopement procedures. They were able to define and give examples of abuse and neglect. They said they would make rounds on all residents every 2 hours and ensure every resident was accounted for. They said if a resident could not be located they would notify the charge nurse. During interviews on [DATE], 4 charge nurses (6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m.) said they were in-serviced on abuse, neglect, and elopement procedures. They were able to define and give examples of abuse and neglect. They said they would make rounds on all residents every 2 hours and ensure every resident was accounted for. They said if a resident could not be located they would notify the administrator or DON. During an interview on [DATE] at 10:12 a.m. the MDS nurse said she reviewed resident's elopement risk assessments and there were no changes in resident's elopement risks. She said residents that resided in the general population were not wanderers or exit seeking. Elopement risk assessments were reviewed for 43 residents and all assessments were completed. On [DATE] at 10:32 a.m., the DON was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all allegations of neglect were reported immediately to the state agency for 1 of 4 resident reviewed for neglect. (Resident #1) The facility did not report to the state when Resident #1, who had underlying health conditions which placed him at risk of infection, eloped from the facility during a global COVID 19 outbreak (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older and people of any age with serious underlying medical problems). Due to the outbreak, residents were to be monitored and checked every two hours for changes in their health. Resident #1 was gone from the facility for more than 7 hours and flew to Portland Oregon before staff realized he was missing. This failure could place the residents at risk for neglect. Findings included: A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and discharged on [DATE]. He had [DIAGNOSES REDACTED]. The face sheet indicated Resident #1 was not his own responsible party and the resident's mother had durable financial power of attorney. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said she was Resident #1's guardian. She said Resident #1 lived in Oregon with his partner and in [DATE] she traveled to Oregon and brought Resident #1 to Texas. She said Resident #1 was confused, weighed less than 120 pounds, was diagnosed with [REDACTED].#1's partner was abusing him. She said when she admitted Resident #1 to the facility, she expressed her concerns about Resident #1 trying to get in contact with his partner and asked staff not to provide him access to phones. Resident #1's mother said she told staff that she was concerned that Resident #1 would elope from the facility and staff assured her he would not elope. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was gravely ill before he admitted to the facility. He said Resident #1 was living in Oregon and had been diagnosed with [REDACTED].#1's mother moved Resident #1 closer to her and he was admitted to the facility. He said Resident #1's mother said she was Resident #1's guardian. A nursing note dated [DATE] at 5:45 p.m. indicated Resident #1 was upset that he had to stay at the facility. The nurse notified the oncoming nurse to watch the resident for possible elopement but noted Resident #1 made no attempt on 2:00 p.m. to 10:00 p.m. shift to elope. An elopement risk assessment dated [DATE] for Resident #1 was initiated but it was not completed and did not indicate if Resident #1 was an elopement risk. A social service note dated [DATE] indicated Resident #1 said he was admitted to the facility for panic attacks and he denied having a stroke. Resident #1 would rather be home but understood that medically he needed to be in the facility. Resident #1 was in an abusive relationship and the stroke affected his short-term memory. A citation on notice of temporary guardianship dated [DATE] and provided by Resident #1's mother, indicated she filed an application for temporary guardianship of Resident #1. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said after her son was admitted , she gave the business office manager a copy of the court ordered guardianship and the business office manager said she would scan the guardianship paperwork into Resident #1's file. During an interview on [DATE] at 11:38 a.m., the business office manager said in [DATE], Resident #1's mother told her that she was trying to obtain guardianship of Resident #1, but she did not provide guardianship paperwork. She said Resident #1's mother signed Resident #1's admission paperwork and signed it as his power of attorney. During an interview on [DATE] at 1:16 p.m., the sheriff's deputy said he went to the facility on [DATE] and served Resident #1 with guardianship papers. He said the guardianship paperwork indicated that Resident #1's mother was Resident #1's guardian. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said a few weeks after she secured the guardianship, she received a call from the facility and was told that the sheriff's department was serving the guardianship paperwork to Resident #1 and Resident #1 was upset. She said her husband went to the facility and calmed Resident #1 down. She said she spoke to Resident #1 on the phone and he understood that she had guardianship over him. A letter of temporary guardianship dated [DATE] provided by Resident #1's mother indicated she was appointed guardian of Resident #1. The temporary guardianship expired on [DATE]. On [DATE] the temporary guardianship was extended until 30 days after [DATE] due to the COVID-19 pandemic. A social service note dated [DATE] indicated Resident #1 would rather be at home (Oregon) or in his own home but was not ready medically or financially. Resident #1 said he liked it at the facility but felt somewhat controlled or restricted by his mother. Resident #1 wanted to have more freedom, but he could leave the facility with family and friends. Physician orders [REDACTED].#1 was ordered Dascovy ,[DATE] mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., Tivicay 50 mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] multivitamin ,[DATE] mg-mcg once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] propionate nasal spray 50 mcg/actuation 2 sprays once a day between 8:00 a.m. and 10:00 a.m., and Bactrim DS ,[DATE] mg (antibiotic)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. BUILDING _____ B. WING _____	04/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR PLACE	507 E W M WATSON BLVD DAINGERFIELD, TX 75638

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) once a day between 8:00 a.m. and 10:00 a.m. to prevent pneumocystis. A Minimum (MDS) data set [DATE] indicated Resident #1 had intact cognition, made his needs known, and understood others. He had no physical, verbal, or wandering behaviors during the review period. Resident #1 was independent with most ADLs. He was continent of bowel and bladder. A care plan last revised on [DATE] indicated Resident #1 had an altered immune system and staff were to follow universal precautions, monitor every two hours and report signs of infection, and provide a private room. The care plan did not address Resident #1's elopement risk. A social service note dated [DATE] indicated Resident #1 wanted to reside in an apartment on his own and staff were working on a discharge plan to get him ready to reside in the community. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said the facility restricted visitors in [DATE] due to COVID-19 but Resident #1 called her during the middle of March and said staff were trying to help him to get out of the facility. Resident #1's mother said she called the facility, but the administrative staff had already left for the day and she spoke to CNA C. She said CNA C confirmed that the facility was trying to find an apartment for Resident #1. Resident #1's mother said she told staff that her son could not live independently. A nursing note dated [DATE] at 11:30 a.m. indicated staff were unable to locate Resident #1 in the facility. The administrator, DON, and the resident's mother were notified. Resident #1 was contacted by cell phone and he said he was safe, and he was headed home to Portland Oregon. Resident #1 said this was what he wanted, and this would make him happy. A Medication Administration Record [REDACTED]. A social service note dated [DATE] at 1:35 p.m. indicated Resident #1 had a desire to leave the facility and get an apartment of his own or return to Oregon and stay with his friend. The note indicated staff were working on a discharge plan and the next step was to assist Resident #1 with getting a disability check, so he would have an income. The social service note indicated that there was a discussion with Resident #1 about traveling or flying at this time and they told him he was at high risk due to COVID-19. Resident #1 left the faciity on [DATE] without staff knowledge and returned to Oregon. Resident #1 told staff his desire was to return to Oregon and he was safe. The social service note indicated Resident #1 was mentally capable of making that decision for himself. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said on [DATE] at 12:02 p.m. an unknown staff from the facility called and asked if Resident #1 was with her because he was not in the facility. She said the staff said Resident #1 was last seen around 3:30 a.m., and at 11:30 a.m. staff realized he was not in the facility. She said staff told her that they found the window in Resident #1's room open and the screen was pushed out. She said Resident #1 missed his morning medications. She said she spoke to Resident #1 a few hours later and he said he was back in Oregon. She said Resident #1 did not have money or a phone, but he somehow was able to get in contact with his partner and flew back to Oregon. During an interview on [DATE] at 2:28 p.m., LVN E said Resident #1 was alert and independent with ADLs. She said she last saw Resident #1 on [DATE] around 3:30 a.m. at the nursing station which was normal for him. She said Resident #1 was usually up during the night and would go to the conference room and call his partner on the facility's phone. LVN E said Resident #1's mother did not want Resident #1 talking to his boyfriend but there was no court order, so he could talk to anyone he wanted. She said Resident #1 would say he wanted to go home every day. She said on the morning of [DATE], Resident #1 did not say anything about wanting to go home. She said after Resident #1 was at the nursing station for a little bit then said he was tired, and he was going to his room. She said that was the last time she saw Resident #1. She said she did not hear any door alarms go off the rest of her shift. During an interview on [DATE] at 1:47 p.m., CNA F said she worked on [DATE] and she took Resident #1's breakfast tray to his room between 8:00 a.m. and 8:30 a.m. She said Resident #1 was not in his room. CNA F said it was normal for Resident #1 not to be in his room because he was independent with ADLs and smoked without supervision. She said she noticed Resident #1's window was open but did not think Resident #1's would have gone out the window. She said she did not report the window being open. She said she left Resident #1's breakfast tray in the room and left. She said if Resident #1 needed anything he would tell staff and she did not check on him like she checked on residents that required ADL assistance. During an interview on [DATE] at 1:25 p.m., LVN A said she worked on [DATE] and went to Resident #1's room to administer his medications about 9:00 a.m. She said Resident #1 was not in his room and his bed looked like it had been slept in. She said it was normal for Resident #1 to be out of his room. She said MA H said she had not seen him. LVN A said she returned to Resident #1's room about 10:30 a.m. and she thought Resident #1 was in his bathroom. She said she went back to Resident #1's room about 11:00 a.m. to 11:30 a.m. and Resident #1's bathroom door was still closed. She said she opened the bathroom door and the bathroom was empty. She said she could not find Resident #1 and she called Resident #1's mother and determined he was not with her. She said the RN supervisor called police. She said when police arrived she walked around the facility with police and noticed Resident #1's window was open and the screen was pushed out. She said when police called Resident #1, he said he was at the airport in Oregon. LVN A said Resident #1's mother told the facility that Resident #1 should not have any contact with his abuser/partner. She said Resident #1 was able to make his own decisions and she was not aware Resident #1's mother had guardianship paperwork. During an interview on [DATE] at 11:13 a.m., MA H said she worked on [DATE] but did not see Resident #1. She said Resident #1 left the facility sometime before 6:00 a.m. She said Resident #1 was alert and usually was not in his room. She said she heard that he went out the window in his room and called a cab. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was alert and had improved significantly since he was admitted , but he did not feel that the resident was cognitively intact enough to live independently. He said Resident #1's immune system was weakened due to his diagnoses. During a telephone interview on [DATE] at 12:58 p.m., Resident #1 said on [DATE] at 4:00 a.m. he left the facility. He said he walked out the door near the smoking area and a cab picked him up from the facility and took him to a local airport. He said he flew to Dallas and then flew to Oregon. He said his partner in Oregon bought his plane tickets a week prior to him leaving. He said he was able to get his medications through a resource in Portland Oregon. Resident #1 said his mother did not have guardianship over him. During an interview on [DATE] at 9:56 a.m., the administrator said they spoke to Resident #1 on [DATE] and he was safe. She said Resident #1 was his own responsible party and they had been working on discharging the resident into the community. She said Resident #1's mother said she was trying to get guardianship of Resident #1 but did not provide any paperwork to the facility. She said Resident #1 was alert and independent with his own care and staff monitored Resident #1 as staff should for independent residents. She said she did not expect LVN A to open the bathroom door when she though Resident #1 was in the bathroom. She said they reviewed video footage and Resident #1 did not walk out any exit door because he was not seen on video. The administrator said the facility was not a prison. During an interview on [DATE] at 3:03 p.m., CNA D said Resident #1 always said he wanted to go back home to Oregon. She said he was alert and independent with most ADLs. She said she was not sure if Resident #1's mother had guardianship of Resident #1. She said Resident #1 did not have a cell phone, but he would go to the conference room and use the phone. During an interview on [DATE] at 11:20 a.m., LVN B said Resident #1 was alert and did not want to be at the facility. She said Resident #1 said he wanted to get an apartment locally but had no idea that he would leave the facility on his own. She said the last time she saw Resident #1 was the day before he left the facility and he did not say anything about leaving the facility. A police report dated [DATE] indicated local police were dispatched at 12:11 p.m. to the facility regarding a missing person. LVN A said Resident #1 was last seen in the facility on [DATE] at 3:30 a.m. by nursing staff. It is believed that Resident #1 left the facility through his room window. The report indicated Resident #1 left the facility to return to Oregon. Resident #1 was no longer considered a missing person on [DATE]. The facility's undated abuse prevention program policy indicated residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility's undated abuse investigation and reporting policy indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment, and/or injuries of unknown source were to be promptly report to local, state, and federal agencies and thoroughly investigated by facility management. Alleged abuse, neglect, exploitation or mistreatment that did not result in serious bodily injury the report were required to be reported within 24 hours.
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 interview and record review, the facility failed to ensure adequate supervision was provided for 1 of 4 residents reviewed for elopement. (Resident #1) The facility did not prevent Resident #1, who had underlying health conditions which placed him at risk of infection, from eloping from the facility during a global COVID 19 outbreak (a new respiratory disease which can cause mild to severe illness with most severe illness in adults [AGE] years and older and people of any age with serious underlying medical problems) Due to the outbreak, residents were to be monitored and checked every two

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) hours for changes in their health. Resident #1 was gone from the facility for more than 7 hours and flew to Portland Oregon before staff realized he was missing. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a level of potential for more than minimal harm with a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for illness, injury, or death. Findings included: A face sheet dated [DATE] indicated Resident #1 was [AGE] years old, admitted on [DATE], and discharged on [DATE]. The face sheet indicated he had [DIAGNOSES REDACTED]. The face sheet indicated Resident #1 was not his own responsible party and the resident's mother had durable financial power of attorney (allows someone else to manage finances if the resident becomes incapacitated). During an interview on [DATE] at 4:41 p.m., Resident #1's mother said she was Resident #1's guardian. She said Resident #1 lived in Oregon with his partner and in [DATE] she traveled to Oregon and brought Resident #1 to Texas. She said Resident #1 was confused, weighed less than 120 pounds, was diagnosed with [REDACTED].#1's partner was abusing him. She said when she admitted Resident #1 to the facility, she expressed her concerns about Resident #1 trying to get in contact with his partner and asked staff not to provide him access to phones. Resident #1's mother said she told staff that she was concerned that Resident #1 would elope from the facility and staff assured her he would not elope. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was gravely ill before he admitted to the facility. He said Resident #1 was living in Oregon and had been diagnosed with [REDACTED].#1's mother moved Resident #1 closer to her and he was admitted to the facility. He said Resident #1's mother said she was Resident #1's guardian. He was unaware that Resident #1 was no longer living in the facility. A nursing note dated [DATE] at 5:45 p.m. indicated Resident #1 was upset that he had to stay at the facility. The nurse notified the oncoming nurse to watch the resident for possible elopement but noted Resident #1 made no attempt on 2:00 p.m. to 10:00 p.m. shift to elope. An elopement risk assessment dated [DATE] for Resident #1 was initiated but it was not completed and did not indicate if Resident #1 was an elopement risk. A social service note dated [DATE] indicated Resident #1 said he was admitted to the facility for panic attacks and he denied having a stroke. Resident #1 would rather be home but understood that medically he needed to be in the facility. Resident #1 was in an abusive relationship and the stroke affected his short-term memory. A citation on notice of temporary guardianship dated [DATE] and provided by Resident #1's mother, indicated she filed an application for temporary guardianship of Resident #1. A care plan last revised on [DATE] indicated Resident #1 had an altered immune system and staff were to follow universal precautions, monitor every two hours and report signs of infection, and provide a private room. The care plan did not address Resident #1's elopement risk. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said after her son was admitted , she gave the business office manager a copy of the court ordered guardianship and the business office manager said she would scan the guardianship paperwork into Resident #1's file. During an interview on [DATE] at 11:38 a.m., the business office manager said in [DATE], Resident #1's mother told her that she was trying to obtain guardianship of Resident #1, but she did not provide guardianship paperwork. She said Resident #1's mother signed Resident #1's admission paperwork and signed it as his power of attorney. During an interview on [DATE] at 1:16 p.m., the sheriff's deputy said he went to the facility on [DATE] and served Resident #1 with guardianship papers. He said the guardianship paperwork indicated that Resident #1's mother was Resident #1's guardian. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said a few weeks after she secured the guardianship, she received a call from the facility and was told that the sheriff's department was serving the guardianship paperwork to Resident #1 and Resident #1 was upset. She said her husband went to the facility and calmed Resident #1 down. She said she spoke to Resident #1 on the phone and he understood that she had guardianship over him. A letter of temporary guardianship dated [DATE] provided by Resident #1's mother indicated she was appointed guardian of Resident #1. The temporary guardianship expired on [DATE]. On [DATE] the temporary guardianship was extended until 30 days after [DATE] due to the COVID-19 pandemic. Physician orders [REDACTED].#1 was ordered Dascovy ,[DATE] mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., Tivicay 50 mg ([MEDICAL CONDITION] to [MEDICAL CONDITION].once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] multivitamin ,[DATE] mg-mcg once a day between 8:00 a.m. and 12:00 p.m., [MEDICATION NAME] propionate nasal spray 50 mcg/actuation 2 sprays once a day between 8:00 a.m. and 10:00 a.m., and Bactrim DS ,[DATE] mg (antibiotic) once a day between 8:00 a.m. and 10:00 a.m. to prevent pneumocystis. A social service note dated [DATE] indicated Resident #1 would rather be at home (Oregon) or in his own home but was not ready medically or financially. Resident #1 said he liked it at the facility but felt somewhat controlled or restricted by his mother. Resident #1 wanted to have more freedom, but he could leave the facility with family and friends. A Minimum (MDS) data set [DATE] indicated Resident #1 had intact cognition, made his needs known, and understood others. He had no physical, verbal, or wandering behaviors during the review period. Resident #1 was independent with most ADLs. He was continent of bowel and bladder. A care plan last revised on [DATE] indicated Resident #1 had an altered immune system and staff were to follow universal precautions, monitor every two hours and report signs of infection, and provide a private room. The care plan did not address Resident #1's elopement risk. A social service note dated [DATE] indicated Resident #1 wanted to reside in an apartment on his own and staff were working on a discharge plan to get him ready to reside in the community. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said the facility restricted visitors in [DATE] due to COVID-19 but Resident #1 called her during the middle of March and said staff were trying to help him to get out of the facility. Resident #1's mother said she called the facility, but the administrative staff had already left for the day and she spoke to CNA C. She said CNA C confirmed that the facility was trying to find an apartment for Resident #1. Resident #1's mother said she told staff that her son could not live independently. A nursing note dated [DATE] at 11:30 a.m. indicated staff were unable to locate Resident #1 in the facility. The administrator, DON, and the resident's mother were notified. Resident #1 was contacted by cell phone and he said he was safe, and he was headed home to Portland Oregon. Resident #1 said this was what he wanted, and this would make him happy. A Medication Administration Record [REDACTED]. A social service note dated [DATE] at 1:35 p.m. indicated Resident #1 had a desire to leave the facility and get an apartment of his own or return to Oregon and stay with his friend. The note indicated staff were working on a discharge plan and the next step was to assist Resident #1 with getting a disability check, so he would have an income. The social service note indicated that there was a discussion with Resident #1 about traveling or flying at this time and they told him he was at high risk due to COVID-19. Resident #1 left the faciity on [DATE] without staff knowledge and returned to Oregon. Resident #1 told staff his desire was to return to Oregon and he was safe. The social service note indicated Resident #1 was mentally capable of making that decision for himself. During an interview on [DATE] at 4:41 p.m., Resident #1's mother said on [DATE] at 12:02 p.m. an unknown staff from the facility called and asked if Resident #1 was with her because he was not in the facility. She said the staff said Resident #1 was last seen around 3:30 a.m., and at 11:30 a.m. staff realized he was not in the facility. She said staff told her that they found the window in Resident #1's room open and the screen was pushed out. She said Resident #1 missed his morning medications. She said she spoke to Resident #1 a few hours later and he said he was back in Oregon. She said Resident #1 did not have money or a phone, but he somehow was able to get in contact with his partner and flew back to Oregon. During an observation on [DATE] at 8:53 a.m., a sign was noted on the front door that visitation was restricted. During an interview on [DATE] at 2:28 p.m., LVN E said Resident #1 was alert and independent with ADLs. She said she last saw Resident #1 on [DATE] around 3:30 a.m. at the nursing station which was normal for him. She said Resident #1 was usually up during the night and would go to the conference room and call his partner on the facility's phone. LVN E said Resident #1's mother did not want Resident #1 talking to his boyfriend but there was no court order, so he could talk to anyone he wanted. She said Resident #1 would say he wanted to go home every day. She said on the morning of [DATE], Resident #1 did not say anything about wanting to go home. She said after Resident #1 was at the nursing station for a little bit then said he was tired, and he was going to his room. She said that was the last time she saw Resident #1. She said she did not hear any door alarms go off the rest of her shift. LVN E said the facility restricted visitors for about a month and required staff to wear masks in the facility. The said appropriate PPE was worn when assisting residents. She said residents were assessed daily for respiratory symptoms and their temperature was checked. She said residents ate their meals in their rooms and spent most of their time in their rooms. She said they monitored residents when they were in common areas to ensure they were a safe distance apart. She said staff had their temperature checked and answered questions regarding symptoms before they were allowed to start their shift. During an interview on [DATE] at 2:46 p.m., CNA C said she and Resident #1 were close. She said Resident #1 told her all the time he was going back to Oregon. She said on [DATE] around 1:00 p.m. she said she called Resident #1 and he said he was going home. She said Resident #1 told her he left the facility through the window in his room and a cab took him to the airport. She said Resident #1's mother told staff she had guardianship over Resident #1 and she did not want Resident #1 talking to his partner. She said she heard there was no

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) guardianship paperwork. She said Resident #1 was alert and independent with ADLs but needed assistance with showers. She said the social worker was finding an apartment for Resident #1 and she said she offered to go to the apartment and assist Resident #1 with showers. During an interview on [DATE] at 10:51 a.m., the social worker said Resident #1 was alert and independent with his care. He said Resident #1's cognition had improved since his admission and he was able to make his own decisions. He said Resident #1's mother said she was trying to get guardianship of Resident #1 but did not provide the facility with any paperwork. He said he had 2 discharge care plan meetings with Resident #1 because Resident #1 wanted to live independently in an apartment. The social worker said Resident #1 did not want his mother to know he wanted to discharge from the facility. He said residents were staying in their rooms most of the time during the COVID-19 restrictions. He said residents ate in their rooms and kept an acceptable distance from other residents when in common areas. He said all staff and essential visitors wore masks in the facility. He said all staff and residents had their temperature checked daily. During an interview on [DATE] at 3:03 p.m., CNA D said Resident #1 always said he wanted to go back home to Oregon. She said he was alert and independent with most ADLs. She said she was not sure if Resident #1's mother had guardianship of Resident #1. She said Resident #1 did not have a cell phone, but he would go to the conference room and use the phone. During an interview on [DATE] at 11:20 a.m., LVN B said Resident #1 was alert and did not want to be at the facility. She said Resident #1 said he wanted to get an apartment locally but had no idea that he would leave the facility on his own. She said the last time she saw Resident #1 was the day before he left the facility and he did not say anything about leaving the facility. During an interview on [DATE] at 1:47 p.m., CNA F said she worked on [DATE] and she took Resident #1's breakfast tray to his room between 8:00 a.m. and 8:30 a.m. She said Resident #1 was not in his room. CNA F said it was normal for Resident #1 not to be in his room because he was independent with ADLs and smoked without supervision. She said she noticed Resident #1's window was open but did not think Resident #1's would have gone out the window. She said she did not report the window being open. She said she left Resident #1's breakfast tray in the room and left. She said if Resident #1 needed anything he would tell staff and she did not check on him like she checked on residents that required ADL assistance. During an interview on [DATE] at 1:25 p.m., LVN A said she worked on [DATE] and went to Resident #1's room to administer his medications about 9:00 a.m. She said Resident #1 was not in his room and his bed looked like it had been slept in. She said it was normal for Resident #1 to be out of his room. She said MA H said she had not seen him. LVN A said she returned to Resident #1's room about 10:30 a.m. and she thought Resident #1 was in his bathroom. She said she went back to Resident #1's room about 11:00 a.m. to 11:30 a.m. and Resident #1's bathroom door was still closed. She said she opened the bathroom door and the bathroom was empty. She said she could not find Resident #1 and she called Resident #1's mother and determined he was not with her. She said the RN supervisor called police. She said when police arrived she walked around the facility with police and noticed Resident #1's window was open and the screen was pushed out. She said when police called Resident #1, he said he was at the airport in Oregon. LVN A said Resident #1's mother told the facility that Resident #1 should not have any contact with his abuser/partner. She said Resident #1 was able to make his own decisions and she was not aware Resident #1's mother had guardianship paperwork. She said residents were assessed daily for respiratory symptoms and had their temperature checked. She said the front door was locked and staff entered the facility through the door where the enclosed smoking area was located. She said staff had their temperature checked and answered a few questions about symptoms before they were allowed to start their shift. She said residents stayed in their rooms most of the time and staff wore masks while in the facility and wore appropriate PPE when working with residents. During an interview on [DATE] at 11:13 a.m., MA H said she worked on [DATE] but did not see Resident #1. She said Resident #1 left the facility sometime before 6:00 a.m. She said Resident #1 was alert and usually was not in his room. She said she heard that he went out the window in his room and called a cab. During an interview on [DATE] at 12:27 p.m., Resident #1's physician said Resident #1 was alert and had improved significantly since he was admitted , but he did not feel that the resident was cognitively intact enough to live independently. He said Resident #1's immune system was weakened due to his diagnoses. During an interview on [DATE] at 9:56 a.m., the administrator said they spoke to Resident #1 on [DATE] and he was safe. She said Resident #1 was his own responsible party and they had been working on discharging the resident into the community. She said Resident #1's mother said she was trying to get guardianship of Resident #1 but did not provide any paperwork to the facility. She said Resident #1 was alert and independent with his own care and staff monitored Resident #1 as staff should for independent residents. She said she did not expect LVN A to open the bathroom door when she though Resident #1 was in the bathroom. She said they reviewed video footage and Resident #1 did not walk out any exit door because he was not seen on video. The administrator said the facility was not a prison. She said the facility began restricting visitors in early [DATE]. She said they posted signs on the front door indicating that visitors were restricted and kept the door locked. She said staff entered and exited the facility through the exit door that led to the enclosed smoking area. The administrator said residents were assessed daily for respiratory symptoms and had their temperature checked. She said they did not have any residents with a temperature of respiratory symptoms. She said staff had their temperature checked and answered a series of questions about travel and symptoms before they were allowed to begin their shift. She said staff were required to wear a mask while in the facility and appropriate PPE when interacting with residents. The administrator said medical and pharmacy suppliers would meet staff outside to ensure no unnecessary visitors came into the facility. She said laboratory services came to the facility on ce a week and obtained all laboratory draws during the visit. The administrator said residents ate their meals in their rooms and staff were monitoring to ensure there was a safe distance between residents. She said staff were in-serviced on infection control, handwashing, and PPE. During a telephone interview on [DATE] at 12:58 p.m., Resident #1 said on [DATE] at 4:00 a.m. he left the facility. He said he walked out the door near the smoking area and a cab picked him up from the facility and took him to a local airport. He said he flew to Dallas and then flew to Oregon. He said his partner in Oregon bought his plane tickets a week prior to him leaving. He said he was able to get his medications through a resource in Portland Oregon. Resident #1 said his mother did not have guardianship over him. A police report dated [DATE] indicated local police were dispatched at 12:11 p.m. to the facility regarding a missing person. LVN A said Resident #1 was last seen in the facility on [DATE] at 3:30 a.m. by nursing staff. It is believed that Resident #1 left the facility through his room window. The report indicated Resident #1 left the facility to return to Oregon. Resident #1 was no longer considered a missing person on [DATE]. The administrator and DON were notified on [DATE] at 9:58 a.m., an IJ situation had been identified due to the above failures. The IJ template was provided to the administrator by email on [DATE] at 10:12 a.m. The facility's Plan of Removal was accepted on [DATE] at 12:08 p.m. and included: 1. All residents have the potential to be affected by this. 2. All current residents have been accounted for. 3. All current residents will have an updated elopement risk assessments completed by close of business [DATE] 4. The Administrator or designee will re-inservice all nursing staff regarding: a. Abuse/neglect b. making rounds to ensure residents are accounted every 2 hours if a CNA cannot account for a residents location they are to notify the charge nurse immediately. If the charge nurse cannot account for a resident's where about they are to notify the administrator and DON immediately. c. Licensed nurses will be re-inserviced on completing an elopement risk assessment on admission d. The MDS Coordinator will complete an elopement risk assessment annually, quarterly and with significant change. All inservicing will be completed by close of business [DATE] 5. The DON/ADON/Administrator or designee will review documentation of every 2 hour checks daily. To begin [DATE] and ongoing. The investigator confirmed the plan of removal had been implemented sufficiently to remove the IJ by: During an interview on [DATE] at 9:14 a.m., the DON said all staff were in-serviced on abuse, neglect, and ensuring residents were accounted for every 2 hours. If a CNA could not locate a resident, they would notify the charge nurse immediately. If the charge nurse could not locate the resident, they would notify the administrator and DON immediately. She said licensed nurses were in-serviced on completing elopement assessments on admission. She said all residents were assessed for elopement risk on [DATE]. She said she was reviewing the documentation that staff were visually accounting for residents every 2 hours. During interviews on [DATE], 6 CNAs and 1 MA (6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m.) said they were in-serviced on abuse, neglect, and elopement procedures. They were able to define and give examples of abuse and neglect. They said they would make rounds on all residents every 2 hours and ensure every resident was accounted for. They said if a resident could not be located they would notify the charge nurse. During interviews on [DATE], 4 charge nurses (6 a.m. to 2 p.m., 2 p.m. to 10 p.m., and 10 p.m. to 6 a.m.) said they were in-serviced on abuse, neglect, and elopement procedures. They were able to define and give examples of abuse and neglect. They said they would make rounds on all residents every 2 hours and ensure every resident was accounted for. They said if a resident could not be located they would notify the administrator or DON. During an interview on [DATE] at 10:12 a.m. the MDS nurse said she reviewed resident's elopement risk assessments and there were no changes in resident's elopement risks. She said residents that resided in the general

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675755	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR PLACE	**507 E W M WATSON BLVD DAINGERFIELD, TX 75638**

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	(continued... from page 6) population were not wanderers or exit seeking. Elopement risk assessments were reviewed for 43 residents and all assessments were completed. On [DATE] at 10:32 a.m., the DON was informed the IJ was removed; however, the facility remained out of compliance at actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.