STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HOUSE OF MARSHALL HEALTH & REHABILITATION	**5915 ELYSIAN FIELDS ROAD MARSHALL, TX 75672**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure adequate supervision was provided to prevent accidents for 1 of 6 residents reviewed for accidents. (Resident #1) The facility did not prevent Resident #1 who had a history of [REDACTED]. Resident #1 was found approximately 50-100 feet away from the facility driveway on the shoulder of a busy highway where the speed limit was 60 miles per hour and no sidewalks. The facility was not aware the resident was missing until the social worker arrived at the facility. An Immediate Jeopardy (IJ) situation was determined to have existed on 6/21/2020 to 7/7/20. It was determined to be past non-compliance due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey. This failure could place residents at risk of accidents, injury, or death. Findings included: A face sheet dated 6/21/2020 indicated Resident #1 was [AGE] years old, was admitted [DATE], and had [DIAGNOSES REDACTED]. An elopement risk assessment dated [DATE] indicated Resident #1 was identified as an elopement risk. A quarterly MDS dated [DATE] indicated Resident #1 was moderately impaired cognitively, wandered daily during the look back period, and required supervision of one staff for locomotion off of her unit. A care plan updated 6/13/2020 indicated Resident #1 would wander at times. The interventions included to monitor the resident's whereabouts frequently, encourage resident to not go outside unsupervised, and have a wander guard system in place. An elopement risk book kept at the nurses' station indicated Resident #1 and 9 other residents were identified as elopement risks. A safe smoking evaluation dated 6/21/2020 indicated Resident #1 must be supervised by staff, volunteer, or family member at all times when smoking. A staff assignment sheet dated 6/21/2020 indicated CNA A was responsible for the 11:00 a.m. smoking break. A witness statement completed by the staffing coordinator dated 6/21/2020 indicated she brought Resident #1 outside for a smoke break at the front of the building where CNA A was waiting. The statement indicated she placed Resident #1's wheelchair next to CNA A and prior to re-entering the building the staffing coordinator reminded CNA A to extinguish Resident #1's cigarette. The statement indicated she was unaware Resident #1 was left outside after the break. A witness statement completed by the SW dated 6/21/2020 indicated she was driving to work when she located Resident #1 on the shoulder of the highway in front of the facility in her wheelchair. The statement indicated she pulled over and notified the facility of the resident being on the side of the highway and she stayed with Resident #1 until staff came to retrieve the resident. A departmental note dated 6/21/2020 indicated Resident #1 was located by the social worker (SW) on the highway by the facility and the staff retrieved the resident and performed an assessment. The resident was placed on 15-minute checks. During an interview on 7/10/20 at 3:22 p.m., the administrator said Resident #1 was discharged with family shortly after the incident on 6/21/20. She said Resident #1 eloped to the end of the driveway and she was about 6 feet from a major highway. The administrator said anyone at the facility's entrance could see the end of driveway and if a resident was at end of driveway staff would be able to see them. She acknowledged no staff knew Resident #1 had eloped until they received a phone call from the SW stating Resident #1 eloped. During an interview on 7/10/20 at 3:32 p.m., LVN B said she was a nurse and did not actually see what happened, she said she was returning from her break on 6/21/20 and was parking her car during the incident. She said Resident #1 was a known wanderer and should have been supervised. During an interview on 7/10/20 at 3:35 p.m., CNA C said herself, CNA A and LVN B were the three staff outside with the residents during smoke break. She said there were several other residents outside. She said on the day of the incident a staff member had returned to facility with ice cream that had started melting and requested CNA A to take the ice cream inside and put away in freezer. CNA C said she punched in the door code for CNA A to go inside since her hands were full. She said CNA A proceeded inside and did not make any other staff aware that she was leaving the smoke area or the residents. CNA C said while she was at the door, another supervisor requested she go remove a brief from a resident's room, so she also went inside the facility and left the residents outside unattended. She said she did not notify other staff to watch the residents for her. She said during the time when Resident #1 eloped from the smoking area, no staff were present. She said she was not aware Resident #1 eloped until the SW called and notified the facility. During an observation and interview on 7/15/2020 at 8:50 a.m., the administrator said CNA A was the one responsible for the residents on the 11:00 a.m. smoke break. She said at the time of the elopement, the facility's line of sight was obscured due to the placement of the facility van and the support columns on the awning. She said at the time Resident #1 was found, there were no staff outside. She said Resident #1 was discharged home with family on 6/24/2020 because she ultimately wanted to go home. She said Resident #1 was found at the doorway 2 more times after the incident, between the 15-minute checks, but was able to be redirected. She said the family agreed it was in Resident #1's best interest to be discharged home. The administrator pointed out the area where Resident #1 was located to the surveyor and she indicated Resident #1 was on the shoulder of the highway closest to the facility approximately 50-100ft from the driveway near a mailbox. During an interview on 7/15/2020 at 9:03 a.m., the staffing coordinator said she took Resident #1 outside for a cigarette on the day she eloped on 6/21/20. She said there were other residents outside and 2 other staff members present. She said she placed Resident #1's wheelchair next to CNA A because of how they interacted together. She said all the staff helped monitor the smoke break, but it was ultimately CNA A's responsibility to get all the residents back inside. She said she did not tell CNA A she was going back inside but reminded her to extinguish Resident #1's cigarette before they all came inside. She said after she came into the facility she did not witness any staff or residents come in after her. She said she was down the hallway when the staff alerted her Resident #1 was outside on the road. She said she asked CNA A if she had brought Resident #1 in after the smoke break and CNA A responded, you're not going to blame that on me, she is not my resident. She said the facility in-serviced the staff on elopement and smoking after the incident. During an interview on 7/15/2020 at 9:34 a.m., the SW said she was scheduled to work 6/21/2020 and when she arrived she noticed Resident #1 outside on the shoulder of the highway (to the left of the driveway) but was headed back towards town (towards the driveway). She said Resident #1 was unable to explain what she was doing. She said traffic was known to speed down the highway, so she used her car as a barrier with her hazard lights on, so the resident would not get injured. She said she notified the facility while she was outside with the resident and within a minute multiple staff were outside to get the resident. She said she notified the administrator of the incident because she was the abuse coordinator. The SW said she had been in-serviced on elopement. She said Resident #1 eventually discharged home because the family did not want her transferred to another facility further away that had a secured unit. During an interview on 7/15/2020 at 10:35 a.m., the administrator said all the other residents who were outside smoking were able to get themselves inside and did not need assistance. She said Resident #1 was the only resident who smoked and needed assistance because she was a wander risk. She said that all residents require supervision during smoke breaks due to safety. She said after the incident they moved the smoking area to the back of the facility and changed all the door codes. During an interview on 7/15/2020 at 10:57 a.m., CNA D said all the residents who smoked besides

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Resident #1 were able to come and go for the smoke breaks without needing assistance. She said Resident #1 was the only one who required supervision outside due to her elopement risk. During an observation on 7/15/20 at 12:00 p.m., the speed limit sign indicated the speed was 60 miles per hour on the highway where Resident #1 was found. During an interview on 7/15/2020 at 12:15 p.m., the administrator said she expected staff to ensure Resident #1 was brought in after her smoke break due to her wandering and elopement risk. She said CNA A should have brought Resident #1 inside since she was responsible for the residents on that smoke break. She said LVN B was not on the clock and was taking a break and CNA C was also on a break and not responsible for the residents at that time. During an interview on 7/15/2020 at 12:23 p.m., CNA C said she stepped outside to take a phone call and there were residents outside, but several had already begun to re-enter the facility. She said she remembered the staffing coordinator telling CNA A to extinguish Resident #1's cigarette because it was getting close to the filter. She said the staffing coordinator went inside. She said the nurse came up with some ice cream, so she opened the door to have CNA A take it inside. She said she did not know if CNA A returned outside to ensure the residents were inside. She said staff are designated to take residents out to smoke and that it is on the CNA assignment sheet at the bottom. During an interview on 7/15/2020 at 1:07 p.m., the administrator said after Resident #1 eloped they did large and small group in-services related to elopement and wandering residents. The facility had staff locate the elopement risk book at the nurses' station. She said she did informal 1-on-1 in-services with CNA A, LVN B, CNA C, and the staffing coordinator. She said they suspended CNA A on 6/21/20 and terminated her on the 6/24/20 because of attendance issues. She said CNA A had not returned to work after being suspended. She said if a resident was a smoker and in the elopement book then they were to be in direct supervision which was essentially within 5 feet of the resident and with a direct line of sight. She said other residents who smoked and were not an elopement risk could have a staff member outside with them, but they do not have to be right next to the smoker. She said that all staff knew where the elopement book was located and if they had a wander guard bracelet they were to be directly supervised when outside of the facility. A facility policy titled Wander and Elopement dated 10/1/07 indicated: .the facility will provide preventive interventions as necessary to help ensure the safety of the resident identified and the safety of other residents residing in the facility An undated facility policy titled Wandering, Unsafe Resident indicated: .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement An undated facility policy titled Smoking Policy- Residents indicated: . 10. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking The administrator, DON, and company Vice President were notified on 7/15/2020 at 3:15 p.m., a past non-compliance situation had been identified due to the above failures. It was determined these failures placed residents in an IJ situation on 6/21/20 to 7/7/20. The facility implemented the following interventions: -assessment of Resident #1, -initiation of 15-minute checks for Resident #1 and her eventual discharge, -completion of in-services regarding Elopement Investigation, Wandering & Elopement, and Wandering/Unsafe Residents; -suspension of CNA A, -placing the elopement incident on the facility's quality assurance program, and -moving the designated smoking area to the back of the facility on 7/7/2020. These interventions were completed based on 7 staff (Administrator, DON, SW, 1 LVN, and 2 CNAs) interviewed to ensure these interventions had been completed. Staff were able to appropriately define abuse, identify the abuse coordinator, and said they would immediately notify the administer or DON of any abuse allegations