STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676132	A. Building B. Wing	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trail Lake Nursing & Rehabilitation	7100 Trail Lake Dr Fort Worth, TX 76133

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, and record review, the facility failed to provide services to prevent neglect for 1 of 5 residents (Resident #1) reviewed for neglect. Resident #1 had an elopement attempt on 10/15/22 where he sat on the facility side street and when found he voiced that he wanted to go home and he had a decrease in his BIMS on 11/10/22 from 13 to 11. The facility failed to address the concerns, assess for elopement, or revise care plan. Resident #1 eloped from the facility on 2/16/23 and his location was unknown for 4 days during freezing temperatures with lows of 27 degrees. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 02/20/23. While the IJ was removed on 02/22/23, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm, and a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for continued neglect, undetected neglect and/or decline in feelings of safety and well-being, and psychosocial harm. Findings included: Review of the facility's undated Abuse Prevention program policy revealed the residents have the right to be from abuse, neglect. Neglect is defined as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Review of Resident #1's progress note dated 10/15/22 at 8:40 AM completed by Nurse O revealed [Resident #1] was seen sitting on the side of the street by someone in the kitchen. Upon observation the resident was seen with a sweater and hat on stating he was wanting to go home to Mississippi Completed head to toe assessment. The resident does not have any skin issues and does not complain of pain.[Resident #1] stated he is ready to go home. Educated [Resident #1] on the proper procedure for signing out when wanting to go outside. [Resident #1] verbalized understanding. Will monitor the resident. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of an event report dated 02/16/23 for Resident #1 completed by LVN H revealed On 2/16/23 at approximately 6:00 AM nurse identified that resident was not in his room. Nurse alerted other staff members and a search was conducted throughout the facility, facility grounds and outside areas surrounding facility. Staff unable to locate resident. Nurse notified DON and DON notified Administrator. At approximately 7:00 AM police and family were notified. Resident was last seen by nurse at 4:30 AM in his room in bed and then again at 4:45 AM heading toward the break room to go get himself a drink. Record review of Resident #1's electronic Face Sheet revealed a [AGE] year-old male who admitted to the facility 04/18/22 with diagnoses that included Cerebral infarction(Stroke), Seizures, Drug induced tremor and schizoaffective disorder(a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania) and Muscle Wasting and Atrophy (the shrinking of muscle or nerve tissue). Resident #1 discharged from the facility on 02/16/23. Record review of Resident #1's MDS dated [DATE] revealed Resident#1's BIMS score was 10 (scores 8 to 12 suggests moderately impaired).The resident required supervision or limited assistance with activities of daily living. Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS of 13 (A score of 13 to 15 suggests the resident was cognitively intact). Review of Resident #1's MDS dated [DATE] revealed a BIMS of 11, indication of being moderately impaired with cognition. Record review of Resident #1's care plan dated 04/18/22 did not address Resident #1's cognition change. Resident #1's care plan revealed no information regarding the resident being at risk for elopement. Record review of Resident #1 electronic health record revealed no elopement assessment had been completed until 02/16/23 after Resident #1 had eloped from the facility. There was no evidence an elopement assessment had been completed prior. Record review of the facility resident sign out binder on 02/17/23 revealed Resident #1 had not sign out of the facility prior to leaving the facility on 02/16/23. Record review of Resident #1's Continuity of care document dated 02/21/23 revealed Resident #1 was prescribed Depakote 250 mg tablet, once a day, with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23 at 9:28 PM. Resident #1's was prescribed Depakote 500 mg tablet, at bedtime with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23 at 9:28 PM. Resident #1 was prescribed oxcarbazepine 150 mg, once a day with the start date of 04/18/22 for seizures, last administered on 02/15/23 at 9:28 PM. Resident #1 was missing due to elopement on 02/16/23. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's February 2023 Medication Administration Record revealed Depakote 250 mg tablet, once a day, with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23. Resident #1's was prescribed Depakote 500 mg tablet, at bedtime with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23. Resident #1 was prescribed oxcarbazepine 150 mg, once a day with the start date of 04/18/22 for seizures, last administered on 02/15/23. Review of all staff education revealed Elopement training was completed on 05/29/22 and again on 02/16/23 after Resident #1 had eloped. An interview with the ADM in 02/17/23 at 1:23 PM revealed Resident #1 had eloped from the facility the morning of 02/16/23 . The ADM stated LVN H had observed Resident #1 at 4:45 am. The ADM did not know where Resident #1 may have traveled. The ADM had contacted Resident #1's family member, the family member would contact the facility if Resident #1 had contact them. The local police department was notified. The ADM was not aware of Resident #1 eloping from the facility previously. The ADM stated Resident #1 walked around the facility freely. She revealed Resident #1 did not have an elopement assessment completed. The ADM stated the MDS coordinator, or the charge nurse should have completed the elopement assessment and updated Resident #1 care plan. The ADM stated facility had not provided education to the facility staff after the 10/15/22 incident .The ADM was told the Resident #1 did not leave the facility premises and was an elopement. The ADM stated when Resident #1 had change in cognition, an elopement assessment should have been completed before allowing the resident to walk throughout the facility without supervision. An interview with the DON on 02/17/23 at 1:44 PM revealed Resident #1's care plan had not been updated to reflect the resident was at risk for elopement . Resident #1 was allowed to go in and out of the facility. Resident #1 was allowed to sit on the front covered outside of the building and was able to sit out on the courtyard. The DON stated he was aware of Resident #1 leaving the facility on 10/15/22 and being located by a kitchen staff. The DON stated his understanding was Resident #1 had not traveled outside of the premises of the facility . The had not completed an elopement assessment following the incident. He had not educated staff regarding Resident #1 being located sitting on the side of the street. Resident #1's care plan was not updated. An interview with LVN A on 02/17/23 at 1:58 PM revealed she worked with Resident #1 since his admission to the facility. Resident #1 was allowed to go out of the facility and sit under the covered patio. Resident #1 was allowed to sit in the courtyard area of the facility. Resident #1 would usually come back inside the faculty after 30 minutes. She was not aware of an elopement assessment not being completed for Resident #1. Resident #1 was not asked to sign out, each time he went outside the facility. An interview with the MDS Coordinator on 02/20/23 at 1:24 PM revealed it was his responsibility to update residents care plans. He worked with the nursing team to come up with interventions. He was responsible for ensuring the elopement assessments were completed. He stated Resident #1's care plan had not been updated since his admission. Resident #1 had a change in cognition since first arriving at the facility. However was not documented on the care plan. He stated following Resident #1 being found sitting on street on 10/15/22, no elopement assessment was completed, no care plan was updated, no staff education regarding Resident #1 change in cognition and his attempted elopement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Care plan, Comprehensive Person Centered policy dated 12/16 revealed 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change. Review of facility's Wandering, Unsafe resident policy dated 08/14 revealed The residents care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. The Administrator was notified on 02/20/23 at 12:50 PM that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on 02/20/23 at 12:51 PM . The facility's Plan of Removal was accepted on 02/22/23 at 9:42 am and included: 2/17/23 All residents were assessed for elopement risk/potential by LVN MDS Coordinator and reviewed by RN Quality Nurse. All residents identified as a risk were immediately added to elopement book by LVN MDS Coordinator. 2/18/23 All residents identified as an elopement risk/potential had care plans updated by LVN MDS Coordinator and reviewed by Director of Nursing. Any resident identified unsafe, and wandering will be placed on one on one supervision until transferred to a more secure facility. On 2/20/23 one resident was identified as an elopement risk, one on one was initiated from nursing staff and the resident was transferred on 2/20/23 to a secured facility. MD notified. Family in agreement of transfer to secured facility. 2/20/23 Chief Operating Officer educated Administrator, DON, and Wound Care LVN on Abuse and Neglect Policy and Procedure and responsibilities of Abuse Coordinator. 2/20/23 Chief Operating Officer educated Administrator on reporting potential allegations of Abuse and Neglect. 2/20/23 Chief Operation Officer educated Administrator on notifying Regional Director of Operations if there is any question regarding reporting Abuse and Neglect. 2/20/23 Chief Operating Officer educated Licensed Social Worker educated on reporting of incidents to Nursing, DON, or Administrator. 2/20/23 LVN, Wound care nurse educated all staff on Abuse and Neglect which was initiated at approximately 1pm for all staff as well as where to find the elopement binder accessible to all nursing staff members. 2/20/23 LVN, Wound Care nurse educated all staff on reporting responsibilities and who and how to report Abuse and Neglect as well as who the Abuse Coordinator is at Trail Lake Nursing and Rehab. 2/20/23 All residents were provided a copy of who the Abuse Coordinator is and to whom to report allegations This was provided by the Administrator and the Activity Director. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	If a resident is determined that a resident is an elopement risk, the resident will be placed on 1 on 1 until a more secure facility can be obtained for the resident. Family and MD will be notified. Staff will not be allowed to take an assignment until in-services are completed. Monitoring: Administrator/DON will review all new admits, readmits and any resident with a significant change to ensure that an elopement risk assessment and care plan is completed. Administrator/MDS will review all residents quarterly to ensure an elopement risk assessment and care plan is completed. Any negative findings will be reported to monthly QAPI meeting for further recommendation and review. On 02/22/23 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of sampled residents health records, revealed care plans and elopement assessments were completed and or updated for all residents. Review of education dated 02/20/23 Abuse and Neglect revealed the ADM was educated on notifying Regional Director of Operations if there was any question regarding reporting Abuse and Neglect presented by the Director of Operations. Review of education dated 02/20/23 completed by the CEO revealed the Administrator was educated on reporting potential allegations of Abuse and Neglect. Review of the Inservice education Abuse and Neglect Policy and Procedure, dated 02/20/23 reveled the ADM, DON was in serviced on Elopement. Both the ADM and DON sign in attendance. An interview with Resident #2 on 02/22/23 at 9:45 am revealed he had been educated on reporting neglect. Record review of the Inservice education Abuse and Neglect Policy and Procedure, dated 02/22/23 revealed staff had been educated regarding neglect. How to report abuse and neglect and to who to report. An interview with facility staff members on 02/22/23 from 10:00 AM to 12:00 PM LVN A, LVN D, HSK Z, HSK Y, LVN B, CNA C, CNA F, CNA G, LVN H, CNA I, HR L and AD M. Each revealed they had been educated regarding neglect. Each were able to articulate with examples of neglect. All allegations of neglect must be reported to the abuse coordinator. An interview with the DON on 02/22/23 at 10:38 AM revealed he had been in serviced regarding reporting of elopements by the ADM. The DON was educated regarding neglect. He explained that failing to provide residents with goods and services was neglect. All nursing staff were responsible for reporting neglect to the abuse coordinator. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the MDS Coordinator on 02/20/23 at 12:29 PM revealed he had been educated regarding resident care plans being updated after a change in condition. He was required to report neglect to the ADM. An interview with the ADM on 02/22/23 at 12:45 PM revealed the facility had implemented that the charge nurses would ensure each resident had an elopement assessment completed upon admission, quarterly and after a change in condition. All staff had been educated regarding neglect and reporting. She had been educated by the CEO on investigating neglect and reporting neglect. On 02/22/23 at 1:10 PM the ADM was notified the IJ was removed. However, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate their corrective actions.

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(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 to resident health or safety Residents Affected - Some	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** 35314 Based on observation, interviews and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (Resident #1) of five residents reviewed for elopement. The facility failed to provide interventions and supervision for Resident #1 from eloping from the facility on 10/15/22 and 02/16/23. Resident#1's location was unknown for 4 days. This failure resulted in an identification of an Immediate Jeopardy (IJ) situation on 02/20/23. While the IJ was removed on 02/22/23, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm, and a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures put residents at risk of serious injury, hospitalization , or even death related to elopements Findings included: Record review of Resident #1's electronic Face Sheet revealed a [AGE] year-old male who admitted to the facility 04/18/22 with diagnoses that included Cerebral infarction(Stroke), Seizures, Drug induced tremor and schizoaffective disorder and Muscle Wasting and Atrophy (the shrinking of muscle or nerve tissue). Resident #1 eloped from the facility on 02/16/23. Record review of Resident #1's MDS dated [DATE] revealed Resident#1's BIMS score was 10 (scores 8 to 12 suggests moderately impaired).The resident required supervision or limited assistance with activities of daily living. Review of Resident #1's admission MDS dated [DATE] revealed a BIMS of 13 (A score of 13 to 15 suggests the resident was cognitively intact). Review of Resident #1's MDS dated [DATE] revealed a BIMS of 11, indication moderately impaired. Record review of Resident #1's care plan dated 04/18/22 reflected no information about Residents #1 cognition change. Resident #1's care plan revealed no information regarding the resident being at risk for elopement. Record review of Resident #1's progress note dated 10/15/22 at 8:40 AM revealed [Resident #1] was seen sitting on the side of the street by someone in the kitchen. Upon observation the resident was seen with a sweater and hat on stating he was wanting to go home to MS. Completed head to toe assessment. The resident does not have any skin issues and does not complain of pain.[Resident #1] stated he is ready to go home. Educated [Resident #1] on the proper procedure for signing out when wanting to go outside. [Resident #1] verbalized understanding. Will monitor the resident. Record review of Resident #1 electronic health record revealed no elopement assessment had been completed until 02/16/23 after Resident #1 had eloped from the facility. There was evidence a elopement assessment had been completed prior. Resident #1 had not sign out of the facility prior to leaving the facility on 02/16/23. (continued on next page)

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(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 to resident health or safety Residents Affected - Some	Record review of an event report dated 02/16/23 for Resident #1 revealed On 2/16/23 at approximately 6:00 AM nurse identified that resident was not in his room. Nurse alerted other staff members and a search was conducted throughout the facility, facility grounds and outside areas surrounding facility. Staff unable to locate resident. Nurse notified DON and DON notified Administrator. At approximately 7:00 AM police and family were notified. Resident was last seen by nurse at 4:30 AM in his room in bed and then again at 4:45 AM heading toward the break room to go get himself a drink. Review of Resident #1's Continuity of care document dated 02/21/23 revealed Resident #1 was prescribed Depakote 250 mg tablet, once a day, with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23 at 9:28 PM. Resident #1's was prescribed Depakote 500 mg tablet, at bedtime with the start date of 04/18/22 for seizures, the medication was last administered on 02/15/23 at 9:28 PM. Resident #1 was prescribed oxcarbazepine 150 mg, once a day with the start date of 04/18/22 for seizures, last administered on 02/15/23 at 9:28 PM. Resident #1 was missing due to elopement on 02/16/23. An interview with the ADM in 02/17/23 at 1:23 PM revealed Resident #1 had eloped from the facility the morning of 02/16/23. The ADM did not know where Resident #1 may have traveled. The ADM had contacted Resident #1's family member, the family member would contact the facility if Resident #1 had contact them. The local police department was notified. The ADM was not aware of Resident #1 eloping from the facility previously. The ADM stated Resident #1 walked around the facility freely. She revealed Resident #1 did not have an elopement assessment completed. The ADM stated the MDS Coordinator or the charge nurse should have completed the elopement assessment and updated Resident #1 care plan. The ADM revealed the document incident with Resident #1 dated on 10/15/22 had not investigated as an elopement , because she was told the resident remained on the premises. An interview with the DON on 02/17/23 at 1:44 PM revealed Resident #1's care plan had not been updated to reflect the resident was at risk for elopement . Resident #1 was allowed to go in and out of the facility. Resident #1 was allowed to sit on the front covered outside of the building and was able to sit out on the courtyard. The DON stated he was aware of Resident #1 leaving the facility on 10/15/22 and being located by a kitchen staff. The DON stated his understanding was Resident #1 had not traveled outside of the premises of the facility. The had not completed an elopement assessment following the incident. He had not educated staff regarding Resident #1 being located sitting on the side of the street. Resident #1 care plan had not being updated. An interview with LVN A on 02/17/23 at 1:58 PM revealed she worked with Resident #1 since his admission to the facility. Resident #1 was allowed to go out of the facility and sit under the covered patio. Resident #1 was allowed to sit in the courtyard area of the facility. Resident #1 would usually come back inside the facility after 30 minutes. She was not aware of an elopement assessment not being completed for Resident #1. Resident #1 was not asked to sign out, each time he went outside the facility. An additional interview with the ADM on 02/20/23 at 10:11 AM revealed she had spoken with Resident #1's family member and revealed on 02/17/23 at 5:00 PM Resident #1 had traveled to the family members home and was turned away. The address of the family member home was approximately 10 miles from the facility. Review of Google maps on 02/20/23 revealed the address of the family member from the facility was 9.7 miles away and would take to 3 hours to walk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the MD on 02/21/23 at 2:23 PM revealed Resident #1 required seizure medication. Resident #1 had eloped from the facility on 02/16/23, it could be very dangerous for Resident #1 to go 4 days without his seizure medication. The MD stated he was told by the facility that Resident #1 had left the faciity on [DATE], however he was not told the resident had eloped. Record review of the weather. com website revealed the low temperature on 02/16/23 was 37 degrees. On 02/17/23 the temperature low was 29 degrees. Review of the Care plan, Comprehensive Person Centered policy dated 12/16 revealed 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change. Review of facility's Wandering, Unsafe resident policy dated 08/14 revealed The residents care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. The Administrator was notified on 02/20/23 at 12:50 PM that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided the Immediate Jeopardy template on 02/20/23 at 12:51 PM . The facility's Plan of Removal was accepted on 02/22/23 at 9:42 AM and included: 2/17/23 All residents were assessed for elopement risk/potential by LVN MDS Coordinator and verified by Director of Nursing. All residents identified as a risk were immediately added to elopement book by Administrator and Activity Director. 2/18/23 All residents identified as an elopement risk/potential had care plans updated by the MDS coordinator and reviewed by DON. Any resident identified unsafe, and wandering will be transferred to a more secure facility. On 2/20/23 one resident was identified as an elopement risk, one on one was initiated from nursing staff and the resident was transferred on 2/20/23 to a secured facility. MD notified. Family in agreement of transfer to secured facility. 2/20/23 Chief Operating Officer in serviced Administrator, DON, and Wound Care LVN on Elopement Policy and Procedure, elopement assessment and frequency, and elopement binder and location. 2/20/23 Director of Quality, RN in serviced LVN MDS Coordinator on elopement assessments and frequency of assessment as well as updating care plans. 2/20/23 LVN, Wound Care Nurse Educated staff on Elopement Risk and assessment which were initiated at approximately 1pm for all staff as well as where to find the elopement binder. 2/20/23 LVN, Wound Care Nurse educated all staff on reporting responsibilities and who and how to report. Staff will not be allowed to take an assignment until in-services are completed. (continued on next page)

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(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 to resident health or safety Residents Affected - Some	Monitoring: Administrator/DON will review all new admits, readmits and any resident with a significant change to ensure that an elopement risk assessment and care plan is completed. Administrator/MDS will review all residents quarterly to ensure an elopement risk assessment and care plan is completed. Any negative findings will be reported to monthly QAPI meeting for further recommendation and review. On 02/22/22 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Review of sampled residents health records, revealed care plans and elopement assessments were completed and or updated for all residents. Review of education dated 02/20/23 Elopement Risk and assessments signed by the facility staff Review of education dated 02/20/23 completed by the Director of Quality, educated provided to the MDS coordinator, his signature was documented. Review of the Inservice education Elopement Policy and Procedure, dated 02/20/23 reveled the ADM, DON and LVN D was in serviced on Elopement. Both the ADM and DON sign in attendance. Review of the resident roster revealed one resident was discharged to another facility on 02/20/23 after being identified at risk for elopement. An interview with facility staff members on 02/22/23 from 10:00 AM to 12:00 PM LVN A, LVN D, HSK Z, HSK Y, LVN B, CNA C, CNA F, CNA G, LVN H, CNA I, HR L and AD M. Each revealed they had been educated regarding elopements. The charge nurses would ensure each resident had an elopement assessment completed upon admission, quarterly and after a change in condition. If a resident was seen outside, the charge nurse must be notified. Each resident must sign out before leaving outside the facility if there was no or little risk for elopement. An interview with LVN D on 02/22/23 at 12:10 PM revealed she had completed education with staff regarding the elopement policy and procedure. The facility had implemented elopement binders at each nurses station and one binder at the front desk. The residents face sheet and picture was located in each binder, residents in the binders were not allowed to leave the facility without supervision. Observation on 02/20/23 of one binder at the north nurses station and one binder at the south nurses' station and one binder was located at the front desk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676132	A. Building B. Wing	02/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trail Lake Nursing & Rehabilitation	7100 Trail Lake Dr Fort Worth, TX 76133

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 to resident health or safety Residents Affected - Some	An interview with the DON on 02/22/23 at 10:38 AM revealed he had been in serviced regarding reporting of elopements by the ADM. The facility had implemented elopement binders at each nurses station and one binder at the front desk. The residents face sheet and picture was located in each binder, residents in the binders were not allowed to leave the facility without supervision. The facility had implemented that the charge nurses would ensure each resident had an elopement assessment completed upon admission, quarterly and after a change in condition. If a resident was seen outside, the charge nurse must be notified. Each resident must sign out before leaving outside the facility if there was no or little risk for elopement. An interview with the MDS Coordinator on 02/20/23 at 12:29 PM revealed he had been educated regarding resident care plans being updated after a change in condition. He must ensure all residents had an elopement assessment completed upon admission, quarterly and after a change in condition. An interview with the ADM on 02/22/23 at 12:45 PM revealed the facility had implemented that the charge nurses would ensure each resident had an elopement assessment completed upon admission, quarterly and after a change in condition. If a resident was seen outside, the charge nurse must be notified. Each resident must sign out before leaving outside the facility if there was no or little risk for elopement. She had been educated by the CEO regarding reporting and investigating elopements. Resident #1 had been located on 02/21/23 at 3:00 PM. Resident #1 did not want to return to the facility. On 02/22/23 at 1:10 PM the ADM was notified the IJ was removed. However, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate their corrective actions.