Printed: 11/20/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/22/2023
NAME OF PROVIDER OR SUPPLIE Trail Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7100 Trail Lake Dr Fort Worth, TX 76133	
For information on the nursing home's	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)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and neglect by anybody. **NOTE- TERMS IN BRACKETS IN Based on observation, interview, a for 1 of 5 residents (Resident #1) in Resident #1 had an elopement attack he voiced that he wanted to go hor facility failed to address the concerthe facility on 2/16/23 and his located degrees. This failure resulted in an identificate removed on 02/22/23, the facility repotential for more than minimal had the effectiveness of the corrective. This failure could place residents a of safety and well-being, and psychesis for more than minimal had the effectiveness of the corrective. This failure could place residents a of safety and well-being, and psychesis included: Review of the facility's undated Ab from abuse, neglect. Neglect is dein physical harm, mental anguish, or Review of Resident #1's progress #1] was seen sitting on the side of seen with a sweater and hat on state assessment. The resident does not he is ready to go home. Educated	empt on 10/15/22 where he sat on the fine and he had a decrease in his BIMS rns, assess for elopement, or revise cartion was unknown for 4 days during free attion of an Immediate Jeopardy (IJ) situation of	confidential control of the residents have the right to be services necessary to avoid the residents have the right to be services necessary to avoid control of pain. [Resident #1] stated for signing out when wanting to go

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 676132

If continuation sheet Page 1 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER (76132 STREET ADDRESS, CITY, STATE, ZIP CODE (7107 frail Lake Dr. Fort Worth, TX 76133				NO. 0936-0391
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) 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 member and a search was conducted throughout the facility, facility grounds and saerch was conducted throughout the facility callity grounds and 30 AM in his room in bed and the again at 4:45 AM heading toward the break room to go get himself a drink. Residents Affected - Some Residents Affected - Some Residents Affected in the staff member as search was conducted throughout the facility and a search was conducted throughout the facility and 30 AM in his room in bed and the 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 of 4/18/22 with alignoses that included Cerebral infarction(Stroke), Seizures, Drug induced remor a 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 mani and Muscle Wasting and Alrophy (the shrinking of muscle or nerve lissue). Resident #1 discharged from the facility on 02/16/23. Record review of Resident #1's MDS dated [DATE] revealed a BIMS of 13 (A score of 13 to 15 suggests moderately impaired). The resident required supervision or limited assistance with activities of daily living. 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 begrated by a element of the facility prior to leaving the facility on 02/16/23. Record		IDENTIFICATION NUMBER:	A. Building	COMPLETED
F 0600 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 member 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 noted Administrator. At approximately 7:00 AM police and family were notified that resident was not in his room. Nurse alerted other staff member and a search was conducted throughout the facility grounds and outside areas surrounding facility. Staff unable to locate resident. Nurse notified DON and DON noted 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 the 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). Selzures, Drug induced tremor ar 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 mani and Muscle Wasting and Atrophy (the shrinking of muscle or nerve tissue). Resident #1 discharged from th 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). 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			7100 Trail Lake Dr	P CODE
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 member 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 the 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 are schizoaffective disorder(a mental health disorder that is marked by a combination of schizophrenia symptoms, such as depression or mani 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 impaire 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 assessment had been completed prior. Record review of Resident #1's continuity of care document dated 02/21/23 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	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Residents Affected - Some Balbased Affected Af	(X4) ID PREFIX TAG			on)
9:28 PM. Resident #1 was prescribed oxcarbazepine 150 mg, once a day with the start date of 04/18/22 fo seizures, last administered on 02/15/23 at 9:28 PM. Resident #1 was missing due to elopement on 02/16/2 (continued on next page)	Level of Harm - Immediate jeopardy to resident health or safety	Review of an event report dated 02 approximately 6:00 AM nurse ident and a search was conducted through Staff unable to locate resident. Nur AM police and family were notified, again at 4:45 AM heading toward to the Record review of Resident #1's elefacility 04/18/22 with diagnoses that schizoaffective disorder(a mental his symptoms, such as hallucinations of and Muscle Wasting and Atrophy (facility on 02/16/23). Record review of Resident #1's ME 12 suggests moderately impaired). daily living. Record review of Resident #1's add suggests the resident was cognitive with cognition. Record review of Resident #1's MDS date with cognition. Record review of Resident #1's car Resident #1's care plan revealed in Record review of Resident #1 elect completed until 02/16/23 after Resident #1's care plan revealed in Record review of the facility resident the facility prior to leaving the facility Record review of Resident #1's Coprescribed Depakote 250 mg tablet was last administered on 02/15/23 bedtime with the start date of 04/18 9:28 PM. Resident #1 was prescrib seizures, last administered on 02/15	2/16/23 for Resident #1 completed by Liffied that resident was not in his room. In the facility, facility grounds and one see notified DON and DON notified Adm. Resident was last seen by nurse at 4: The break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of the break room to go get himself a drink of t	VN H revealed On 2/16/23 at Nurse alerted other staff members instrator. At approximately 7:00 30 AM in his room in bed and then c. ear-old male who admitted to the Seizures, Drug induced tremor and bination of schizophrenia oms, such as depression or mania) Resident #1 discharged from the s BIMS score was 10 (scores 8 to nited assistance with activities of BIMS of 13 (A score of 13 to 15 ation of being moderately impaired Resident #1's cognition change. sing at risk for elopement. The energy was no evidence an I Resident #1 had not sign out of 23 revealed Resident #1 was 18/22 for seizures, the medication and Depakote 500 mg tablet, at a with the start date of 04/18/22 for

AND PLAN OF CORRECTION IDENTIF 676132 NAME OF PROVIDER OR SUPPLIER Trail Lake Nursing & Rehabilitation For information on the nursing home's plan to corre (X4) ID PREFIX TAG SUMMA (Each def F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Review after Remember The ADI			
Trail Lake Nursing & Rehabilitation For information on the nursing home's plan to correspond to the corresponding state of the c	OVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/22/2023
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Review after Re An intermorning where R member The ADI	ect this deficiency, please cor	ntact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Review after Re An intermorning where R member The ADI	RY STATEMENT OF DEFIG	CIENCIES of full regulatory or LSC identifying informat	ion)
elopeme education facility p elopeme facility w An intervitor reflect Resident courtyar by a kito premise educate was not An intervito the fa was allo after 30 Resident An intervice the fa An intervito the fa was allo after 30 Resident An intervice the fa was allo after 40 An intervice the fa	review of Resident #1's Fence a day, with the start day. Resident #1's was presoures, the medication was larges, the medication was larges, the medication reveals ident #1 had eloped. View with the ADM in 02/17 of 02/16/23. The ADM states ident #1 may have traver would contact the facility freely. Seed. The ADM stated the Ment assessment and update for the facility staff after the tremises and was an elope ent assessment should have in the facility. Without supervision. View with the DON on 02/17 the resident was at risk for the facility. The had not the facility. The had not the facility. The had not staff regarding Resident updated. View with LVN A on 02/17/cility. Resident #1 was allowed to sit in the courtyard minutes. She was not awant #1 was not asked to signification. He worked we give with the MDS Coordings care plans. He worked we give with the MDS Coordings care plans. He worked we give he elopement assessment.	abruary 2023 Medication Administration ate of 04/18/22 for seizures, the medical prize and period of 04/18/22 for seizures, the medical prize at a different covered on 02/15/23. Resident date of 04/18/22 for seizures, last administered on 02/15/23. Resident date of 04/18/22 for seizures, last administered on 02/15/23. Resident date of 04/18/22 for seizures, last administered on 02/15/23. Resident date of 04/18/22 for seizures, last administered LVN H had observed Resident #1 leled. The ADM had contacted Resident fif Resident #1 had contact them. The logent #1 eloping from the facility previous the revealed Resident #1 did not have a lDS coordinator, or the charge nurse shed Resident #1 care plan. The ADM states the 10/15/22 incident .The ADM was to be been completed before allowing the logical property of Resident #1 was allowed the front covered outside of the building aware of Resident #1 leaving the facility in the side of the logical property of the facility and sit uncarea of the facility. Resident #1 would are of an elopement assessment not be a rout, each time he went outside the facility the nursing team to come up with intents were completed. He stated Resided dent #1 had a change in cognition since the facility had a condition of the stated Resided dent #1 had a change in cognition since	Record revealed Depakote 250 mg ation was last administered on me with the start date of 04/18/22 #1 was prescribed oxcarbazepine nistered on 02/15/23. on 05/29/22 and again on 02/16/23 and eloped from the facility the at 4:45 am. The ADM did not know it #1's family member, the family local police department was notified. By The ADM stated Resident #1 an elopement assessment lould have completed the ated facility had not provided the Resident #1 did not leave the #1 had change in cognition, an resident to walk throughout the s care plan had not been updated to go in and out of the facility. It is gand was able to sit out on the ity on 10/15/22 and being located and not traveled outside of the int following the incident. He had not the street. Resident #1's care plan the Resident #1 since his admission let the covered patio. Resident #1 usually come back inside the faculty ling completed for Resident #1. if was his responsibility to update atterventions. He was responsible for the #1's care plan had not been

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	residents are ongoing and care pla condition change. Review of facility's Wandering, Unsindicate the resident is at risk for elsuch as a detailed monitoring plan. The Administrator was notified on Odue to the above failures. The Administrator was notified on Odue to the above failures. The Administrator was 2/17/23 All residents were assesse RN Quality Nurse. All residents ide Coordinator. 2/18/23 All residents identified as a Coordinator and reviewed by Direct placed on one on one supervision of On 2/20/23 one resident was identified the resident was transferred on 2/2 secured facility. 2/20/23 Chief Operating Officer edue Policy and Procedure and responsional 2/20/23 Chief Operating Officer edue Neglect. 2/20/23 Chief Operating Officer edue Neglect. 2/20/23 Chief Operating Officer edue Neglect. 2/20/23 Chief Operating Officer edue Nursing, DON, or Administrator. 2/20/23 LVN, Wound care nurse edapproximately 1pm for all staff as we members. 2/20/23 All residents were provided as who 2/20/23 All residents were provided as who 2/20/23 All residents were provided as well as who	prehensive Person Centered policy dated 12/16 revealed 13. Asset plans are revised as information about the residents and the residents are revised as information about the residents and the residents are revised as information about the residents and the residents are for elopement or other safety issues. Interventions to try to maintar plan will be included. If on 02/20/23 at 12:50 PM that an Immediate Jeopardy situation were administrator was provided the Immediate Jeopardy template on was accepted on 02/22/23 at 9:42 am and included: It is identified as a risk were immediately added to elopement book to be as an elopement risk/potential had care plans updated by LVN MD Director of Nursing. Any resident identified unsafe, and wandering sion until transferred to a more secure facility. It identified as an elopement risk, one on one was initiated from nursing 2/20/23 to a secured facility. MD notified. Family in agreement of the reducated Administrator, DON, and Wound Care LVN on Abuse ponsibilities of Abuse Coordinator. For educated Administrator on reporting potential allegations of Abuse and Neglect. For educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of incident educated Licensed Social Worker educated on reporting of Incident Educated Licensed Social Worker educated On reporting of Incident Educated Licensed Social Worker educated On reporting Plane Pla	

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F 0600 Level of Harm - Immediate	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.		
jeopardy to resident health or safety		assignment until in-services are comple	eted.
Residents Affected - Some	Monitoring: Administrator/DON will review all n	ew admits, readmits and any resident v	with a significant change to ensure
	that an elopement risk assessment	and care plan is completed.	
	Administrator/MDS will review all re is completed.	esidents quarterly to ensure an elopem	ent risk assessment and care plan
	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 to IJ by:		removal sufficiently to remove the
		Record review of sampled residents health records, revealed care plans and elopement assessments were completed and or updated for all residents.	
		ated 02/20/23 Abuse and Neglect revealed the ADM was educated on notifying perations if there was any question regarding reporting Abuse and Neglect presented ations.	
	Review of education dated 02/20/2 reporting potential allegations of Al	02/20/23 completed by the CEO revealed the Administrator was educated on	
		Abuse and Neglect Policy and Procedupement. Both the ADM and DON sign in	
	An interview with Resident #2 on 0	2/22/23 at 9:45 am revealed he had be	en educated on reporting neglect.
		cation Abuse and Neglect Policy and P neglect. How to report abuse and negl	
An interview with facility staff members on 02/22/23 from 10:00 AM to 12:00 PM LVN A, LVN II Y, LVN B, CNA C, CNA F, CNA G, LVN H, CNA I, HR L and AD M. Each revealed they had be regarding neglect. Each were able to articulate with examples of neglect. All allegations of negreported to the abuse coordinator.			revealed they had been educated
	elopements by the ADM. The DON	2/23 at 10:38 AM revealed he had beer was educated regarding neglect. He ewas neglect. All nursing staff were resp	explained that failing to provide
	(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 ADM on 02/22 nurses would ensure each resident after a change in condition. All staff educated by the CEO on investigat On 02/22/23 at 1:10 PM the ADM wompliance at a severity level of no	ator on 02/20/23 at 12:29 PM revealed after a change in condition. He was red 2/23 at 12:45 PM revealed the facility he had an elopement assessment complification in the properties of the prop	quired to report neglect to the ADM. and implemented that the charge eted upon admission, quarterly and and reporting. She had been ever, the facility remained out of the than minimal harm that is not

			NO. 0936-0391
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Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is accidents. **NOTE- TERMS IN BRACKETS Hased on observation, interviews a adequate supervision to prevent accompleted until 02/16/23. Resident#1 The facility failed to provide interve 10/15/22 and 02/16/23. Resident#1 This failure resulted in an identificar removed on 02/22/23, the facility repotential for more than minimal har the effectiveness of the corrective state of the corrective state of the facility 04/18/22 with diagnoses that schizoaffective disorder and Muscle #1 eloped from the facility on 02/16 Record review of Resident #1's ME 12 suggests moderately impaired). Adaily living. Review of Resident #1's car cognition change. Resident #1's car cognition change. Resident #1's car elopement. Record review of Resident #1's car elopement. Record review of Resident #1's prositting on the side of the street by some sweater and hat on stating he was resident does not have any skin isshome. Educated [Resident #1] on the #1 verbalized understanding. Will in Record review of Resident #1 elect completed until 02/16/23 after Resident #1 elect completed until 02/16/23 after Resident endown the side of the street by the sweater and resident #1 elect completed until 02/16/23 after Resident #1 elect completed e	AVE BEEN EDITED TO PROTECT Condition record reviews, the facility failed to ecidents for one (Resident #1) of five rentions and supervision for Resident #1 's location was unknown for 4 days. It is not an Immediate Jeopardy (IJ) situation of serious injury, hospitalization, or eventually deviated and Atrophy (the shrinking of Serious injury, hospitalization, or eventually and Atrophy (the shrinking of Jeopard II) situation of serious injury, hospitalization, or eventually serious	les adequate supervision to prevent ONFIDENTIALITY** 35314 ensure residents received sidents reviewed for elopement. from eloping from the facility on action on 02/20/23. While the IJ was a level of no actual harm with the let to the facility's need to evaluate en death related to elopements ear-old male who admitted to the Seizures, Drug induced tremor and f muscle or nerve tissue). Resident as BIMS score was 10 (scores 8 to nited assistance with activities of ed a BIMS of 13 (A score of 13 to MDS dated [DATE] revealed a rmation about Residents #1 ing the resident was seen with a head to toe assessment. The sident #1] stated he is ready to go en wanting to go outside. [Resident mere was evidence a elopement in the left assessment and the left assessment had been here was evidence a elopement.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	AM nurse identified that resident w conducted throughout the facility, falocate resident. Nurse notified DON family were notified. Resident was AM heading toward the break room. Review of Resident #1's Continuity Depakote 250 mg tablet, once a da administered on 02/15/23 at 9:28 F the start date of 04/18/22 for seizur Resident #1 was prescribed oxcard last administered on 02/15/23 at 9: An interview with the ADM in 02/17 morning of 02/16/23. The ADM did Resident #1's family member, the f The local police department was not previously. The ADM stated Reside have an elopement assessment co should have completed the elopem the document incident with Residers she was told the resident remained. An interview with the DON on 02/1' to reflect the resident was at risk for Resident #1 was allowed to sit on the courtyard. The DON stated premises of the facility. The had not being updated. An interview with LVN A on 02/17/2 to the facility. Resident #1 was allowed after 30 minutes. She was not awa Resident #1 was not asked to sign. An additional interview with the AD family member and revealed on 02 and was turned away. The address.	of care document dated 02/21/23 reversely, with the start date of 04/18/22 for sely. With the start date of 04/18/22 for sely. With the start date of 04/18/22 for sely. Resident #1's was prescribed Departs, the medication was last administer of 28 PM. Resident #1 was missing due to 28 PM. Resident #1 was missing due to 28 PM. Resident #1 was missing due to 29 PM. Resident #1 may have amily member would contact the facility of 29 pm between the ADM was not aware of Resident #1 walked around the facility freely. In the ADM stated the MDS Content assessment and updated Resident #1 dated on 10/15/22 had not investign on the premises. 7/23 at 1:44 PM revealed Resident #1's relopement. Resident #1 was allowed the front covered outside of the building aware of Resident #1 leaving the facility his understanding was Resident #1 had to completed an elopement assessment #1 being located sitting on the side of the providence of the facility. Resident #1 would use of an elopement assessment not being out, each time he went outside the facility. And outside the facility and sit underse of the facility. Resident #1 would use of an elopement assessment not being out, each time he went outside the facility. And outside the facility and sit underse of the facility. Resident #1 would use of the facility. Resident #1 had transfer of the family member home was approved.	staff members and a search was unding facility. Staff unable to oproximately 7:00 AM police and om in bed and then again at 4:45 staled Resident #1 was prescribed sizures, the medication was last akote 500 mg tablet, at bedtime with led on 02/15/23 at 9:28 PM. Start date of 04/18/22 for seizures, to elopement on 02/16/23. Indeed eloped from the facility the electraveled. The ADM had contacted by if Resident #1 had contact them. Ident #1 eloping from the facility. She revealed Resident #1 did not ordinator or the charge nurse of the transport of the the facility. It is an elopement on 10/15/22 and being located at the graph and the facility on 10/15/22 and being located do not traveled outside of the the street. Resident #1 care plan had not he street for Resident #1 care plan had not he street. Resident #1 care plan had not he street with the street had not he str

CTATEMENT OF BEFORE 1995	(VI) PDO///PED/GUEST 151	(70) MILITIDE E CONCETTION	(VZ) DATE CUEVEN	
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 SUPPLI	 ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Trail Lake Nursing & Rehabilitation	1	7100 Trail Lake Dr		
		Fort Worth, TX 76133		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	EFICIENCIES d by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety	Resident #1 had eloped from the fa	02/21/23 at 2:23 PM revealed Resident #1 required seizure medication. the facility on 02/16/23, it could be very dangerous for Resident #1 to go 4 days n. The MD stated he was told by the facility that Resident #1 had left the facility not told the resident had eloped.		
Residents Affected - Some	Record review of the weather. com 02/17/23 the temperature low was	website revealed the low temperature 29 degrees.	on 02/16/23 was 37 degrees. On	
		view of the Care plan, Comprehensive Person Centered policy dated 12/16 revealed 13. Assessment idents are ongoing and care plans are revised as information about the residents and the residents addition change.		
	indicate the resident is at risk for el	of facility's Wandering, Unsafe resident policy dated 08/14 revealed The residents care plan will the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, a detailed monitoring plan will be included. Ininistrator was notified on 02/20/23 at 12:50 PM that an Immediate Jeopardy situation was identified above failures. The Administrator was provided the Immediate Jeopardy template on 02/20/23 at M.		
	I .			
	The facility's Plan of Removal was	accepted on 02/22/23 at 9:42 AM and	included:	
		assessed for elopement risk/potential by LVN MDS Coordinator and verified by idents identified as a risk were immediately added to elopement book by Director. fied as an elopement risk/potential had care plans updated by the MDS by DON. Any resident identified unsafe, and wandering will be transferred to a last identified as an elopement risk, one on one was initiated from nursing staff and an one of 2/20/23 to a secured facility. MD notified. Family in agreement of transfer to		
		serviced Administrator, DON, and Wou ment and frequency, and elopement bir		
	2/20/23 Director of Quality, RN in s of assessment as well as updating	Quality, RN in serviced LVN MDS Coordinator on elopement assessments and frequence well as updating care plans.		
		Nurse Educated staff on Elopement Risk and assessment which were initiated staff as well as where to find the elopement binder.		
	2/20/23 LVN, Wound Care Nurse e	educated all staff on reporting responsib	pilities and who and how to report.	
	Staff will not be allowed to take an	assignment until in-services are comple	eted.	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED	
	676132	B. Wing	02/22/2023	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	STREET ADDRESS, CITY, STATE, ZIP CODE	
Trail Lake Nursing & Rehabilitation	1	7100 Trail Lake Dr Fort Worth, TX 76133		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	TATEMENT OF DEFICIENCIES cy must be preceded by full regulatory or LSC identifying information)		
F 0689	Monitoring:			
Level of Harm - Immediate jeopardy to resident health or safety	Administrator/DON will review all n that an elopement risk assessment	ew admits, readmits and any resident was and care plan is completed.	vith a significant change to ensure	
Residents Affected - Some	Administrator/MDS will review all re is completed.	esidents quarterly to ensure an elopem	ent risk assessment and care plan	
	Any negative findings will be report	ted to monthly QAPI meeting for further	recommendation and review.	
	On 02/22/22 the surveyor confirme IJ by:	d the facility implemented their plan of	removal sufficiently to remove the	
	Review of sampled residents healtl completed and or updated for all re	h records, revealed care plans and elopesidents.	pement assessments were	
	Review of education dated 02/20/23 Elopement Risk and assessments signed by the facility staff			
	Review of education dated 02/20/2 coordinator, his signature was doct	ucation dated 02/20/23 completed by the Director of Quality, educated provided to the MDS is signature was documented.		
	I .	the Inservice education Elopement Policy and Procedure, dated 02/20/23 reveled the ADM, DON was in serviced on Elopement. Both the ADM and DON sign in attendance.		
	Review of the resident roster reveal being identified at risk for elopement	lent roster revealed one resident was discharged to another facility on 02/20/23 after		
	Y, LVN B, CNA C, CNÁ F, CNA G, regarding elopements. The charge completed upon admission, quarte	with facility staff members on 02/22/23 from 10:00 AM to 12:00 PM LVN A, LVN D, HSI A C, CNA F, CNA G, LVN H, CNA I, HR L and AD M. Each revealed they had been experients. The charge nurses would ensure each resident had an elopement assessment admission, quarterly and after a change in condition. If a resident was seen outside must be notified. Each resident must sign out before leaving outside the facility if there		
	An interview with LVN D on 02/22/23 at 12:10 PM revealed she had completed education with staff representation the elopement policy and procedure. The facility had implemented elopement binders at each nurse and one binder at the front desk. The residents face sheet and picture was located in each binder, refine the binders were not allowed to leave the facility without supervision.			
	Observation on 02/20/23 of one bir and one binder was located at the	n 02/20/23 of one binder at the north nurses station and one binder at the south nurses' star was located at the front desk.		
	(continued on next page)			

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/22/2023
NAME OF PROVIDER OR SUPPLIE Trail Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7100 Trail Lake Dr Fort Worth, TX 76133	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	EIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	elopements by the ADM. The facilit binder at the front desk. The reside binders were not allowed to leave to charge nurses would ensure each a quarterly and after a change in con Each resident must sign out before. An interview with the MDS Coordin resident care plans being updated elopement assessment completed. An interview with the ADM on 02/2: nurses would ensure each resident after a change in condition. If a resimust sign out before leaving outsided educated by the CEO regarding repo2/21/23 at 3:00 PM. Resident #1 on 02/22/23 at 1:10 PM the ADM wompliance at a severity level of no	2/23 at 10:38 AM revealed he had beer y had implemented elopement binders ints face sheet and picture was located the facility without supervision. The facinesident had an elopement assessment dition. If a resident was seen outside, the leaving outside the facility if there was actor on 02/20/23 at 12:29 PM revealed after a change in condition. He must end upon admission, quarterly and after a concept of the facility of the charge number of the facility if there was no or little risk porting and investigating elopements. For the facility of the facility of the facility of the facility. Was notified the IJ was removed. However, actual harm with the potential for more of the facility of the facility's need to every the facility of the facility of the facility.	at each nurses station and one in each binder, residents in the lity had implemented that the t completed upon admission, he charge nurse must be notified. The no or little risk for elopement. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition. The had been educated regarding asure all residents had an change in condition.