

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/23/2024
NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 3 residents (Resident #2 and #1), in that:</p> <ol style="list-style-type: none"> Resident #2 was able to exit the building without staff knowing on 3/15/2024; staff were unaware Resident #2 had wheeled himself to a bus stop on a city sidewalk and was gone until he was brought back by police; staff were unaware that Resident #2 had exit seeking behavior although it was in his admission paperwork. Resident #1 was able to exit the building without staff knowing on 3/19/2024; staff were unaware Resident #1 had exited the building and her whereabouts are still unknown. <p>This failure could place resident at risk of neglect resulting in elopements that could have resulted in serious injury, harm, impairment or death.</p> <p>An IJ was identified on 03/22/2024. The IJ template was provided to the facility on [DATE] at 05:50 PM. While the IJ was removed on 03/23/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facilities need to evaluate the effectiveness of their corrective actions.</p> <p>The findings were:</p> <ol style="list-style-type: none"> Record review of Resident #2 Administration Record dated 3/24/2024, revealed Resident #2 was a [AGE] year-old male originally admitted on [DATE] with diagnosis listed as: unspecified heart failure. Other active diagnosis included deaf, non-speaking; functional quadriplegia [completely immobile due to severe disability or frailty]; schizoaffective disorder bipolar type [mental health disorder marked by a combination of symptoms such as hallucinations or delusions, mood disorder symptoms such as depression or mania]. Further review a discharge date of [DATE] to another nursing facility in the area. <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of the quarterly MDS assessment dated [DATE], revealed Resident #2 was coded as highly impaired [absence of useful] hearing with unclear speech; ability to express ideas and wants was coded as usually understood; ability to understand others was coded as sometimes understands in Section B - Hearing, Speech, and Vision. In Section C - Cognitive Patterns, Resident #2 was coded as No for Should BIMS be Conducted due to resident is rarely/never understood; with Disorganized Thinking continuously present, does not fluctuate. In Section D - Mood, Resident #2 was coded as being short-tempered, easily annoyed, rarely felt lonely or isolated from those around you; In Section E - Behavior, Resident #2 was coded as none of the above for indicators of psychosis [hallucinations, delusions]. In Section GG - Functional Abilities, Resident #2 was coded as normally utilizing a wheelchair. Resident #2 was coded as substantial/maximal assistance [helper does more than half the effort] for wheel 50 feet with two turns, and wheel 150 feet with a manual wheelchair.</p> <p>Record review of Resident # 2's All-Inclusive Admission with Baseline Care Plan, dated 11/09/2023, revealed the resident was at risk for wandering with a wandering risk score of 3. Under the subheading for vision, 4.) Residents' ability to see an adequate light and with glasses if used was coded as highly or severely impaired - sees only lights, colors, etcetera or no vision.</p> <p>Record review of referral documents from previous hospital admission, revealed under Emergency Department Medical Screen Exam on 11/03/2023 at 1:18, Resident #2 was deaf and communicates via sign language; does not want to go back to the group home .; wants to go into a nursing home. Reexamination on 11/03/2023 at 1:58 PM, presents to emergency department because he is unhappy with his living situation. At 11/03/2023 at 12:05 PM, documentation reveals, Informed that the patient [Resident #2] has been denied at multiple NH [nursing homes] because of behavioral issues he has had in the past. Under the History & Physical section dated 11/03/2023 at 3:28 PM, patient wanting a new placement and refusing to leave . Progress Note dated 11/05/2023 at 3:03 PM revealed, Resident #2 called 911 from group home .30 minutes after discharge from a hospital in [redacted] . upset due to circumstances.</p> <p>Record review of Behavior Note, dated 3/10/2024 at 5:57 AM, authored by LVN A revealed Resident #2, seen him going out the front door, wanting nurse to call 911.</p> <p>Record review of Behavior Note, dated 3/16/2024 at 2:03 AM, authored by LVN A revealed, Resident #2 found by police at bus stop, police was called by persons walking by for wellness check, policy finally got [Resident #2] to return to facility .EMS came, unable to take him since he is not critique [critical]. I had to station an aide at front door so resident wouldn't go back to bus stop. We need a inside lock on [front door] so this situation would not happen again.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Internal Investigation Summary dated 3/16/2024, revealed Timeline of Event: 3/16/2024 at 12:48 AM Administrator received call from LVN A to inform the police have brought Resident #2 to the facility from the bus stop at the end of the parking lot on the city sidewalk. Resident #2 had wheeled himself to the bus stop without notifying a nurse or any other staff. Resident #2 told the police officer he wanted to go to the hospital. EMS was contacted at Resident #2's request; paramedics assessed the resident and declined to transfer to the hospital; resident declined head to toe assessment by DON at that time; resident uncooperative and upset; the next afternoon resident insisted that the doctor be called so he could be sent to the hospital; Attending physician was called and an order was obtained to transfer him to [Hospital]; Resident from [another major city] area originally where he had a habit of going to the hospital and then going to a different facility; Ended up in [this area] because he became hard to place in [another major city] area due to his behaviors; While inpatient at the hospital he requested another facility to be found and a social worker has been working to facilitate a transfer; Facility was willing to accept the resident back from the hospital; According to his mother, Resident #2 had past behaviors such as he will go to a hospital and not want to leave.</p> <p>Record review of handwritten statement dated 3/18/24, authored by LVN A revealed, statement, on 10-6 shift, while at the nurses' station north, vital check of Resident #2. Resident #2 was watching TV in the ding room between 10-11pm on 3/15/24.</p> <p>Record review of In-Servicing dated 3/16/24 included topics: Abuse and Neglect, and Resident Rights. The In-Servicing was signed by 18 staff.</p> <p>2.Record review of Resident #1's Admission Record, dated 3/22/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included: type 2 diabetes mellitus with foot ulcer secondary to resistance to multiple antibiotics, and cellulitis [an infection whereas bacteria enter through a break in the skin that causes swelling, pain, redness, warmth to the affected area, and requires antibiotic treatment].</p> <p>Record review of Resident #1's baseline care plan, dated 3/19/2024 at 6:49 PM, revealed Resident #1 had a wandering risk score of 1 indicative of low risk for wandering.</p> <p>Record review of referral documents from previous hospital admission, revealed under the heading Chief Complaint, dated 3/15/2024 at 5:05 PM, [Resident #1] occasionally telling nurses she wants to leave AMA. Under the heading Pre-Procedure Diagnosis, drug abuse (methamphetamine). Under the heading History of Present Illness, [Resident #1], is homeless and unable to take care of feet/obtaining medication. Under the heading, History - Adult longitudinal, Resident #1 had drug use: Meth/amphetamines, drug screen positive at admission.</p> <p>Record review of skilled nursing notes dated 3/19/2024 at 9:26 PM, authored by LVN C, Resident #1 arrived at the facility at 6:30 PM . Resident #1 Found in dining room at about 8:30 PM about to light a cigarette . Resident #1 Redirected to smoking courtyard. Resident #1 last seen by staff walking towards smoking courtyard at about 8:30 PM wearing clothing that she arrived in from the hospital [disposable paper scrubs]. during last medication round at 9:00 PM Resident #1 was not observed in her room and subsequently could not be found in the building. Missing resident protocols initiated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of handwritten note entitled hospitals called, dated 3/20/2024 at 3:48 PM revealed 10 different local hospitals contact information indicating they had been contacted regarding Resident #1.</p> <p>Record review of [hospital] Patient Visit Information documents, dated 3/20/2024, revealed under the heading medication dose and instructions included medication dose and instructions, Resident #1 had a prescription for Bactrim, an antibiotic, to be taken twice a day for 14 days. Documents included information on Food Resources in the area.</p> <p>In an interview on 3/20/2024 at 5:05 PM, the DON stated, with the current census being low [49 at the time of interview], current staffing was very good. The DON stated the facility staffed 3 CNAs on the morning [6a-2p] and afternoon [2p-10p] shifts, and 2 CNAs on overnights. The DON stated the facility staffed 2 nurses on all shifts. The DON stated the ADON came in early, that she [the DON] stayed late, and the Treatment Nurse usually worked in the middle, an 8a-5p shift. The DON stated that there is a MA on each of the morning and afternoon shifts. The DON stated the medical records clerk and the ADM both have active CNA certifications and will jump in to work the floor when necessary. The DON stated the front desk receptionist position is usually 8a-5p, but there is flexibility for her to flex her shift as she needs to.</p> <p>In an interview on 3/20/2024 at 5:55 PM, the DON stated Resident #1 left no personal belongs behind when she eloped. The DON stated that Resident #1 was homeless and a drug addict. The DON stated Resident #2 had a known behavior in another major metropolitan area of requesting to go to the hospital, where he would refuse to return to his previous facility, and request alternative placement be found. The DON stated this was how he ended up in this area and ultimately in the facility. The DON stated Resident #2 was now difficult to place in that area. The DON stated that she wanted to give people a chance which is why she took these two residents despite their predilections for problematic behaviors. The DON stated the facility typically does not take residents that pace or have exit seeking elopement behaviors.</p> <p>In an interview on 3/20/2024 at 6:20 PM, MA F stated on 3/19/2024 at around 8:30 PM, he had been standing at the medication cart position just outside of a resident's room in the process of preparing that residents medications when he saw Resident #1 was at dining room table in the process of lighting a cigarette. He notified a staff member closer to Resident #1 to redirect Resident #1 to the smoking courtyard. He stated he saw Resident #1 walking towards that smoking courtyard. He stated that around 9:00 PM he was notified by his nurse, LVN B that Resident #1 was not in her room and was needed for medication administration. MA F stated the two of them, MA F and LVN B, went to look for the Resident #1 in the smoking courtyard. MA F stated upon not finding her there they initiated the facilities missing persons protocol and began a facility wide search.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 3/20/24 at 6:35 PM LVN B stated Resident #1 had arrived to the facility around 6:30 PM on 3/19/2024; and had dinner. Another staff member, MA F, notified him that Resident #1 was attempting to smoke in the dining room, so MA F redirected Resident #1 to smoke in the courtyard. Around 9:00 PM LVN B realized Resident #1 was not in her room, and LVN B needed to give her evening meds. LVN B went down to the smoking courtyard and did not find Resident #1 there. LVN B initiated an all staff search of the facility an exterior of the building. LVN B notified the DON and the ADM that Resident #1 had eloped. LVN B stated the local Police Department was notified, and a report was filed; Local Police declined to initiate a missing person report due to Resident #1's previous drug seeking behaviors and homelessness. LVN B stated he thought there were cameras in the parking lot but was not sure if they actually worked.</p> <p>In an interview on 3/20/24 at 6:55 PM, Resident # 3 stated he did not actually see the lady [Resident #1] leave. Resident #3 stated he had a brief conversation along the lines of hi how are you in the vestibule /waiting area and Resident #1 replied she was waiting for someone. Resident #3 stated he went about looking for a book to read and later noticed Resident #1 was gone and assumed she was picked up by whoever she had been waiting for. Resident # 3 stated Resident #1 had a small red bag and was wearing the paper hospital top and bottom. Resident #3 stated she did not seem upset and was calm when he saw her. Resident # 3 stated he thought it was around 8:30 PM or 9:00 PM yesterday [3/19/2024] when this occurred.</p> <p>In an interview on 3/20/24 at 7:00 PM, the ADM stated the facility did not have cameras. The ADM stated the doors do not alarm or chime upon opening. The ADM stated after hours the doors automatically lock behind you but can be opened from the inside.</p> <p>In an interview on 3/21/24 at 2:00 PM, Ombudsman stated she had not yet been informed of any elopement at this facility; Ombudsman A stated she did not have any concerns about this facility or elopements knowing the type of residents housed at this facility; Ombudsman A stated that since the new administrator and DON started at this facility, things have really turned around - patient morale and outlook has improved and things have really gotten better at this facility. Ombudsman A stated for the census this facility has a very good staffing ratio.</p> <p>In an interview on 3/21/2024 at 3:45 PM, the DON stated this facility does not normally admit residents with elopement/exit seeking behaviors; DON stated the recent in services included enhanced observations of behaviors that might lead to elopement/exit seeking behaviors such as expressions of dissatisfaction, increased aggression or agitation or statements to that effect. The DON stated this facility was not equipped for residents with significant behaviors for elopement or wandering. The DON stated those residents are diverted to one of their sister facilities that has a locked unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 3/21/2024 at 5:30 PM with Charge Nurse RN E at the local emergency room for [Hospital], stated Resident #1 presented to the emergency roiaqnom on [DATE] at 10:48 PM with anxiety and heel pain. Charge nurse RN E stated Resident # 1 was seen by [ER Physician]. Charge nurse RN E stated Resident #1 was not administered any medication while in the emergency room . Resident #1 was given paper prescriptions for medications to treat the infection and her regular maintenance medications. Resident #1 was also provided information on available food resources. Charge nurse RN E stated Resident #1 was alert and oriented times 4 [person, place, time, situation]. Resident #1 disposition was discharged home with medications. Charge nurse RN E stated while in the emergency room , Resident #1 did not reveal she was homeless or would have any difficulty obtaining the prescriptions. Charge nurse RN E stated while in the emergency room , Resident #1 did not reveal that she had eloped from the facility.</p> <p>In an interview and observation on 3/22/2024 at 2:15 PM with the ADM and the DON present, the ADM stated a new alarm system had been installed on the interior door to the vestibule area last night. The Administrator stated during the daytime hours a chime will sound anytime that door was opened. The Administrator further stated between the hours of 8:00 PM and 6:00 AM the nurses would enter a code that would switch the alarm from a chime to an alarm. The Administrator further stated after 8:00 PM, or when receptionist left for the day, an alarm would sound anytime that door was opened. The alarm required passcode be entered before the alarm would stop sounding. The Administrator stated the chime could be heard throughout the facility, even to the furthest points of resident occupied areas. and the alarm was louder and can be heard throughout the facility even to the furthest points of resident occupied areas.</p> <p>Record review of In-Service training report/attendance record dated 3/19/2024 included topics: Abuse Neglect, Resident Rights, Monitoring Signs of Possible Elopement Risk. It included 26 staff signatures.</p> <p>Record review of the facility's Wandering, And Elopement policy revised March 2019, revealed: if identified as at risk for wandering, elopement or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety. 2.) if an employee observes a resident leaving . attempt to prevent; Request assistance from other staff; Instruct another staff member to alert management 3.) if a resident is missing, initiate the elopement/missing resident emergency procedure: a determine if the resident is out on an unauthorized leave of absence; b.) if the resident was not on an unauthorized leave, initiate a search of the facility, grounds and immediate area surrounding the building; c.) if the resident is not in any of the searched areas notify the administrator, director of nursing, family/responsible party and law enforcement officials.</p> <p>Record review of In-Service training report dated 3/20/2024 on the topic of Alerts and Meaning; Contents or summary of training . Code green - missing residents. This training was conducted by the DON and included signatures of 22 staff members.</p> <p>The facility's Plan of Removal was accepted on 03/23/2024 at 7:51 A.M. and included:</p> <p>F600- Immediate Action</p> <p>Notify The Medical Director of the Immediate Jeopardy status.</p> <p>Resident # 1 and Resident #2 are no longer residing at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified.</p> <p>Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 10 pm on 03/22/2024.</p> <p>Alarm was installed on the dining room door to the front office, which contains the outside exit door.</p> <p>The alarm is turned on nightly as the receptionist leaves at 8:00 pm by the Charge Nurse. The alarm will remain off during daytime hours when the front office area is monitored by the receptionist.</p> <p>The charge nurse will check the alarm and door every two hours to ensure they are on and functioning.</p> <p>The alarm will remain turned on throughout the weekend.</p> <p>The alarm checks will be documented on a log included with the abatement plan.</p> <p>Training on the door alarm will be completed by Sunday, 03/24/24, at noon.</p> <p>Inservice staff on elopement/missing resident protocols, which includes color-coded announcements and search areas.</p> <p>For new admissions, when staff conduct routine checks, they will discuss with residents the resident's comfort, orientation, and understanding of facility rules, such as the process to check out when going on pass. These conversations will be in addition to the orientation provided by the admitting charge nurse.</p> <p>The charge nurse will turn on the front door alarm after the receptionist leaves - no later than 8:00 p.m.-and document the action on a check log. Staff will be in service to answer door alarms after the start of the new process and quarterly thereafter.</p> <p>The Clinical Liaison and Marketer and the Admissions Director/designee will carefully scan records to ensure residents are appropriate for facility services and will make residents aware of efforts to assist resident's plan for discharge. The Admissions Director/designee will review the procedures for signing in and out for a pass. For after-business-hours admissions, the nurse admitting the resident will cover these steps during the assessment and orientation process for the resident.</p> <p>The administrator and DON will provide education on the Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy, with a focus on the need to monitor residents going in and out of the dining room front door and monitoring the front door alarm. The target date for training completion is Sunday, 03/24/24, by noon.</p> <p>New employees and agency nurses (if used) will be educated on the alarms and resident monitoring during orientation and before starting their initial shift.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>f. If the resident is not in the searched areas, notify the Administrator, the Director of Nursing, the family/responsible party, and law enforcement officials.</p> <p>When the resident returns to the facility, the director of nursing services or charge nurse shall:</p> <p>g. Notify staff and examine the resident for injuries.</p> <p>h. Notify the physician and medical director of the resident return and assessment findings.</p> <p>i. Notify the family/ responsible party.</p> <p>Verification included:</p> <p>Notify The Medical Director of the Immediate Jeopardy status.</p> <p>Verified via interview with Medical Director [Name of MD], on 3/23/24 at 1:12 PM, she was notified of the IJ at on 3/22/24 at 6:45 PM.</p> <p>Resident # 1 and Resident #2 are no longer residing at the facility.</p> <p>Verified, via interview with The DON on 3/23/24 at 1:24 P.M., that Resident # 1 was discharged from the facility on 3/20/24 at 107 P.M., and Resident # 2 was discharged from the facility on 3/19/24 at 10:00 P.M.</p> <p>The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified.</p> <p>Verified, Elopement assessments completed on electronic medical records for 49 of 49 residents.</p> <p>Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 10 pm on 03/22/2024.</p> <p>Verified, on 3/23/24 via Interview with DON, that none of the 49 current residents were identified as High Risk.</p> <p>Alarm was installed on the dining room door to the front office, which contains the outside exit door.</p> <p>Verified by surveyor on 3/23/24 at 10:45 a.m. upon entrance that dining room door to front office is present and functioning.</p> <p>The alarm is turned on nightly as the receptionist leaves at 8:00 pm by the Charge Nurse. The alarm will remain off during daytime hours when the front office area is monitored by the receptionist.</p> <p>Verified, via an interview with The Administrator on 3/23/24 at 120 p.m., that the alarm is turned on by the receptionist nightly at 8:00 P.M. Verified that the alarm is monitored during daytime hours by the receptionist.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Verified, via logbook noted on south wing of [name of Nursing Home] on 3/23/24 at 210 P.M that night shift nurses monitor alarm after 8:00 p.m.</p> <p>The charge nurse will check the alarm and door every two hours to ensure they are on and functioning.</p> <p>Verified, via log book signatures noted on south wing of [Name of Nursing Home] on 3/23/24 at 210 P.M that night shift nurses monitor alarm after 8:00 p.m.</p> <p>The alarm will remain turned on throughout the weekend.</p> <p>Verified, by surveyor on 3/23/24 at 10:45 a.m. upon entrance that alarm is on and functioning.</p> <p>The alarm checks will be documented on a log included with the abatement plan.</p> <p>Verified, via log book signatures noted on south wing of [name of Nursing Home] on 3/23/24 at 210 P.M .</p> <p>Training on the door alarm will be completed by Sunday, 03/24/24, at noon.</p> <p>Verified, completed training for Door alarms was completed by 54/54 employees, noted with signatures acknowledging in-service.</p> <p>Inservice staff on elopement/missing resident protocols, which includes color-coded announcements and search areas.</p> <p>Verified, Inservice elopement/missing resident protocols staff signatures and interviews with the DON, ADON, and the Administrator revealed DON and ADON were trained step by step in elopement/missing resident protocols procedure on 03/22/23 to cover immediacy by the Administrator. DON and ADON were brought into the office, provided a copy of the procedure, and were able to verbalize understanding of the procedure. See the in-service sheets attached.</p> <p>For new admissions, when staff conduct routine checks, they will discuss with residents the resident's comfort, orientation, and understanding of facility rules, such as the process to check out when going on pass. These conversations will be in addition to the orientation provided by the admitting charge nurse.</p> <p>Verified, in-service elopement/missing resident protocols was completed via in-service elopement /missing resident protocols was completed by (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, and (2) 10 pm-0600 am LVN's.</p> <p>The charge nurse will turn on the front door alarm after the receptionist leaves - no later than 8:00 p.m.-and document the action on a check log. Staff will be in service to answer door alarms after the start of the new process and quarterly thereafter.</p> <p>Verified via in-service elopement /missing resident protocols was completed for: (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, (2) 10 pm-0600 am LVN's. and (2) receptionists.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Clinical Liaison and Marketer and the Admissions Director/designee will carefully scan records to ensure residents are appropriate for facility services and will make residents aware of efforts to assist resident's plan for discharge. The Admissions Director/designee will review the procedures for signing in and out for a pass. For after-business-hours admissions, the nurse admitting the resident will cover these steps during the assessment and orientation process for the resident.</p> <p>Verified, via in-service signature, elopement /missing resident protocols was completed by The Clinical Liaison, Marketer, and Admissions Director.</p> <p>Verified via in-service elopement /missing resident protocols was completed by (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, (2) 10 pm-0600 am LVN's.</p> <p>The administrator and DON will provide education on the Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy, with a focus on the need to monitor residents going in and out of the dining room front door and monitoring the front door alarm. The target date for training completion is Sunday, 03/24/24, by noon.</p> <p>Verified, via record review of the in-service sheet Titled Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy reflected 54 staff members' signatures. 11 LVNs, 2 RNs, 12 CMA's, 11 Administrative personnel, 10 Therapists, 3 housekeepers, and 6 dietary staff. 24 out of 54 staff members interviewed (8 LVN, 2 RN, 6 Therapy, 3 Administrative, 5 dietary) verified Inservice.</p> <p>New employees and agency nurses (if used) will be educated on the alarms and resident monitoring during orientation and before starting their initial shift.</p> <p>Verified via interview with the DON on 3/23/24 at 235 P.M. that no new licensed nurses have been hired since this IJ, and only one agency nurse has been used by the [Name of Nursing home] since the IJ.</p> <p>An interview with LVN A on 3/23/24 at 245 p.m. confirmed that she was in-serviced and educated on the alarms and resident monitoring. Before starting her shift on 3/22/23 at 9:30 P.M. by the DON.</p> <p>The Administrator and Director of Nurses will educate the Clinical Liaison and the Admissions Director on reviewing referral paperwork and on the importance of identifying information that may need to be reviewed by the Director of Nursing before acceptance. This will ensure that residents accepted for admission are appropriate for the facility and do not require a secured facility. Residents deemed unsafe for admission due to wandering behaviors will not be admitted . Training will be completed by Sunday, 03/24/24, at noon.</p> <p>Verified via interview with Clinical Liaison and Admissions Director on 3/23/24 at 245 pm that they were in-serviced on referral paperwork that may need to be reviewed by the Administrator and the DON.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Upon admission, the Admissions Director and/ or designee will discuss facility rules with the resident and responsible party regarding signing in and out to go on pass. The charge nurse admitting the resident will further discuss the facility rules for exiting the facility and will assess the elopement risk of the new resident. If it is determined at any time post-admission that a resident is no longer safe and needs a secured unit, the resident will have 1:1 monitoring until safely discharged to an appropriate facility. Education will be provided on this process to the Department Managers, including the Admission Director [TRUNCATED]</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 2 of 3 residents (Resident #2 and #1) reviewed for neglect., in that:</p> <ol style="list-style-type: none"> 1. Resident #2 was able to exit the building without staff knowing on 3/15/2024; staff were unaware Resident #2 had wheeled himself to a bus stop on a city sidewalk and was gone until he was brought back by police; staff were unaware that Resident #2 had exit seeking behavior although it was in his admission paperwork. 2. Resident #1 was able to exit the building without staff knowing on 3/19/2024; staff were unaware Resident #1 had exited the building and her whereabouts are still unknown. <p>This failure could place resident at risk of neglect resulting in elopements that could have resulted in serious injury, harm, impairment, or death.</p> <p>An IJ was identified on 03/22/2024. The IJ template was provided to the facility on [DATE] at 05:50 PM. While the IJ was removed on 03/23/2024, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because the facilities need to evaluate the effectiveness of their corrective actions.</p> <p>The findings were:</p> <ol style="list-style-type: none"> 1. Record review of Resident #2 Administration Record dated 3/24/2024, revealed Resident #2 was a [AGE] year-old male originally admitted on [DATE] with diagnosis listed as: unspecified heart failure. Other active diagnosis included deaf, non-speaking; functional quadriplegia [completely immobile due to severe disability or frailty]; schizoaffective disorder bipolar type [mental health disorder marked by a combination of symptoms such as hallucinations or delusions, mood disorder symptoms such as depression or mania]. Further review a discharge date of [DATE] to another nursing facility in the area. <p>Record review of the quarterly MDS assessment dated [DATE], revealed Resident #2 was coded as highly impaired [absence of useful] hearing with unclear speech; ability to express ideas and wants was coded as usually understood; ability to understand others was coded as sometimes understands in Section B - Hearing, Speech, and Vision. In Section C - Cognitive Patterns, Resident #2 was coded as No for Should BIMS be Conducted due to resident is rarely/never understood; with Disorganized Thinking continuously present, does not fluctuate. In Section D - Mood, Resident #2 was coded as being short-tempered, easily annoyed, rarely felt lonely or isolated from those around you; In Section E - Behavior, Resident #2 was coded as none of the above for indicators of psychosis [hallucinations, delusions]. In Section GG - Functional Abilities, Resident #2 was coded as normally utilizing a wheelchair. Resident #2 was coded as substantial/maximal assistance [helper does more than half the effort] for wheel 50 feet with two turns, and wheel 150 feet with a manual wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident # 2's All-Inclusive Admission with Baseline Care Plan, dated 11/09/2023, revealed the resident was at risk for wandering with a wandering risk score of 3. Under the subheading for vision, 4.) Residents' ability to see an adequate light and with glasses if used was coded as highly or severely impaired - sees only lights, colors, etcetera or no vision.</p> <p>Record review of referral documents from previous hospital admission, revealed under Emergency Department Medical Screen Exam on 11/03/2023 at 1:18, Resident #2 was deaf and communicates via sign language; does not want to go back to the group home .; wants to go into a nursing home. Reexamination on 11/03/2023 at 1:58 PM, presents to emergency department because he is unhappy with his living situation. At 11/03/2023 at 12:05 PM, documentation reveals, Informed that the patient [Resident #2] has been denied at multiple NH [nursing homes] because of behavioral issues he has had in the past. Under the History & Physical section dated 11/03/2023 at 3:28 PM, patient wanting a new placement and refusing to leave . Progress Note dated 11/05/2023 at 3:03 PM revealed, Resident #2 called 911 from group home .30 minutes after discharge from a hospital in [redacted] . upset due to circumstances.</p> <p>Record review of Behavior Note, dated 3/10/2024 at 5:57 AM, authored by LVN A revealed Resident #2, seen him going out the front door, wanting nurse to call 911.</p> <p>Record review of Behavior Note, dated 3/16/2024 at 2:03 AM, authored by LVN A revealed, Resident #2 found by police at bus stop, police was called by persons walking by for wellness check, policy finally got [Resident #2] to return to facility .EMS came, unable to take him since he is not critique [critical]. I had to station an aide at front door so resident wouldn't go back to bus stop. We need a inside lock on [front door] so this situation would not happen again.</p> <p>Record review of Internal Investigation Summary dated 3/16/2024, revealed Timeline of Event: 3/16/2024 at 12:48 AM Administrator received call from LVN A to inform the police have brought Resident #2 to the facility from the bus stop at the end of the parking lot on the city sidewalk. Resident #2 had wheeled himself to the bus stop without notifying a nurse or any other staff. Resident #2 told the police officer he wanted to go to the hospital. EMS was contacted at Resident #2's request; paramedics assessed the resident and declined to transfer to the hospital; resident declined head to toe assessment by DON at that time; resident uncooperative and upset; the next afternoon resident insisted that the doctor be called so he could be sent to the hospital; Attending physician was called and an order was obtained to transfer him to [Hospital]; Resident from [another major city] area originally where he had a habit of going to the hospital and then going to a different facility; Ended up in [this area] because he became hard to place in [another major city] area due to his behaviors; While inpatient at the hospital he requested another facility to be found and a social worker has been working to facilitate a transfer; Facility was willing to accept the resident back from the hospital; According to his mother, Resident #2 had past behaviors such as he will go to a hospital and not want to leave.</p> <p>Record review of handwritten statement dated 3/18/24, authored by LVN A revealed, statement, on 10-6 shift, while at the nurses' station north, vital check of Resident #2. Resident #2 was watching TV in the ding room between 10-11pm on 3/15/24.</p> <p>Record review of In-Servicing dated 3/16/24 included topics: Abuse and Neglect, and Resident Rights. The In-Servicing was signed by 18 staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. Record review of Resident #1's Admission Record, dated 3/22/2024, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included: type 2 diabetes mellitus with foot ulcer secondary to resistance to multiple antibiotics, and cellulitis [an infection whereas bacteria enter through a break in the skin that causes swelling, pain, redness, warmth to the affected area, and requires antibiotic treatment].</p> <p>Record review of Resident #1's baseline care plan, dated 3/19/2024 at 6:49 PM, revealed Resident #1 had a wandering risk score of 1 indicative of low risk for wandering.</p> <p>Record review of referral documents from previous hospital admission, revealed under the heading Chief Complaint, dated 3/15/2024 at 5:05 PM, [Resident #1] occasionally telling nurses she wants to leave AMA. Under the heading Pre-Procedure Diagnosis, drug abuse (methamphetamine). Under the heading History of Present Illness, [Resident #1], is homeless and unable to take care of feet/obtaining medication. Under the heading, History - Adult longitudinal, Resident #1 had drug use: Meth/amphetamines, drug screen positive at admission.</p> <p>Record review of skilled nursing notes dated 3/19/2024 at 9:26 PM, authored by LVN C, Resident #1 arrived at the facility at 6:30 PM. Resident #1 Found in dining room at about 8:30 PM about to light a cigarette. Resident #1 Redirected to smoking courtyard. Resident #1 last seen by staff walking towards smoking courtyard at about 8:30 PM wearing clothing that she arrived in from the hospital [disposable paper scrubs]. during last medication round at 9:00 PM Resident #1 was not observed in her room and subsequently could not be found in the building. Missing resident protocols initiated.</p> <p>Record review of handwritten note entitled hospitals called, dated 3/20/2024 at 3:48 PM revealed 10 different local hospitals contact information indicating they had been contacted regarding Resident #1.</p> <p>Record review of [hospital] Patient Visit Information documents, dated 3/20/2024, revealed under the heading medication dose and instructions included medication dose and instructions, Resident #1 had a prescription for Bactrim, an antibiotic, to be taken twice a day for 14 days. Documents included information on Food Resources in the area.</p> <p>In an interview on 3/20/2024 at 5:05 PM, the DON stated, with the current census being low [49 at the time of interview], current staffing was very good. The DON stated the facility staffed 3 CNAs on the morning [6a-2p] and afternoon [2p-10p] shifts, and 2 CNAs on overnights. The DON stated the facility staffed 2 nurses on all shifts. The DON stated the ADON came in early, that she [the DON] stayed late, and the Treatment Nurse usually worked in the middle, an 8a-5p shift. The DON stated that there is a MA on each of the morning and afternoon shifts. The DON stated the medical records clerk and the ADM both have active CNA certifications and will jump in to work the floor when necessary. The DON stated the front desk receptionist position is usually 8a-5p, but there is flexibility for her to flex her shift as she needs to.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 3/20/2024 at 5:55 PM, the DON stated Resident #1 left no personal belongs behind when she eloped. The DON stated that Resident #1 was homeless and a drug addict. The DON stated Resident #2 had a known behavior in another major metropolitan area of requesting to go to the hospital, where he would refuse to return to his previous facility, and request alternative placement be found. The DON stated this was how he ended up in this area and ultimately in the facility. The DON stated Resident #2 was now difficult to place in that area. The DON stated that she wanted to give people a chance which is why she took these two residents despite their predilections for problematic behaviors. The DON stated the facility typically does not take residents that pace or have exit seeking elopement behaviors.</p> <p>In an interview on 3/20/2024 at 6:20 PM, MA F stated on 3/19/2024 at around 8:30 PM, he had been standing at the medication cart position just outside of a resident's room in the process of preparing that residents medications when he saw Resident #1 was at dining room table in the process of lighting a cigarette. He notified a staff member closer to Resident #1 to redirect Resident #1 to the smoking courtyard. He stated he saw Resident #1 walking towards that smoking courtyard. He stated that around 9:00 PM he was notified by his nurse, LVN B that Resident #1 was not in her room and was needed for medication administration. MA F stated the two of them, MA F and LVN B, went to look for the Resident #1 in the smoking courtyard. MA F stated upon not finding her there they initiated the facilities missing persons protocol and began a facility wide search.</p> <p>In an interview on 3/20/24 at 6:35 PM LVN B stated Resident #1 had arrived to the facility around 6:30 PM on 3/19/2024; and had dinner. Another staff member, MA F, notified him that Resident #1 was attempting to smoke in the dining room, so MA F redirected Resident #1 to smoke in the courtyard. Around 9:00 PM LVN B realized Resident #1 was not in her room, and LVN B needed to give her evening meds. LVN B went down to the smoking courtyard and did not find Resident #1 there. LVN B initiated an all staff search of the facility an exterior of the building. LVN B notified the DON and the ADM that Resident #1 had eloped. LVN B stated the local Police Department was notified, and a report was filed; Local Police declined to initiate a missing person report due to Resident #1's previous drug seeking behaviors and homelessness. LVN B stated he thought there were cameras in the parking lot but was not sure if they actually worked.</p> <p>In an interview on 3/20/24 at 6:55 PM, Resident # 3 stated he did not actually see the lady [Resident #1] leave. Resident #3 stated he had a brief conversation along the lines of hi how are you in the vestibule /waiting area and Resident #1 replied she was waiting for someone. Resident #3 stated he went about looking for a book to read and later noticed Resident #1 was gone and assumed she was picked up by whoever she had been waiting for. Resident # 3 stated Resident #1 had a small red bag and was wearing the paper hospital top and bottom. Resident #3 stated she did not seem upset and was calm when he saw her. Resident # 3 stated he thought it was around 8:30 PM or 9:00 PM yesterday [3/19/2024] when this occurred.</p> <p>In an interview on 3/20/24 at 7:00 PM, the ADM stated the facility did not have cameras. The ADM stated the doors do not alarm or chime upon opening. The ADM stated after hours the doors automatically lock behind you but can be opened from the inside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 3/21/24 at 2:00 PM, Ombudsman stated she had not yet been informed of any elopement at this facility; Ombudsman A stated she did not have any concerns about this facility or elopements knowing the type of residents housed at this facility; Ombudsman A stated that since the new administrator and DON started at this facility, things have really turned around - patient morale and outlook has improved and things have really gotten better at this facility. Ombudsman A stated for the census this facility has a very good staffing ratio.</p> <p>In an interview on 3/21/2024 at 3:45 PM, the DON stated this facility does not normally admit residents with elopement/exit seeking behaviors; DON stated the recent in services included enhanced observations of behaviors that might lead to elopement/exit seeking behaviors such as expressions of dissatisfaction, increased aggression or agitation or statements to that effect. The DON stated this facility was not equipped for residents with significant behaviors for elopement or wandering. The DON stated those residents are diverted to one of their sister facilities that has a locked unit.</p> <p>In an interview on 3/21/2024 at 5:30 PM with Charge Nurse RN E at the local emergency room for [Hospital], stated Resident #1 presented to the emergency roiaom on [DATE] at 10:48 PM with anxiety and heel pain. Charge nurse RN E stated Resident # 1 was seen by [ER Physician]. Charge nurse RN E stated Resident #1 was not administered any medication while in the emergency room . Resident #1 was given paper prescriptions for medications to treat the infection and her regular maintenance medications. Resident #1 was also provided information on available food resources. Charge nurse RN E stated Resident #1 was alert and oriented times 4 [person, place, time, situation]. Resident #1 disposition was discharged home with medications. Charge nurse RN E stated while in the emergency room , Resident #1 did not reveal she was homeless or would have any difficulty obtaining the prescriptions. Charge nurse RN E stated while in the emergency room , Resident #1 did not reveal that she had eloped from the facility.</p> <p>In an interview and observation on 3/22/2024 at 2:15 PM with the ADM and the DON present, the ADM stated a new alarm system had been installed on the interior door to the vestibule area last night. The Administrator stated during the daytime hours a chime will sound anytime that door was opened. The Administrator further stated between the hours of 8:00 PM and 6:00 AM the nurses would enter a code that would switch the alarm from a chime to an alarm. The Administrator further stated after 8:00 PM, or when receptionist left for the day, an alarm would sound anytime that door was opened. The alarm required passcode be entered before the alarm would stop sounding. The Administrator stated the chime could be heard throughout the facility, even to the furthest points of resident occupied areas. and the alarm was louder and can be heard throughout the facility even to the furthest points of resident occupied areas.</p> <p>Record review of In-Service training report/attendance record dated 3/19/2024 included topics: Abuse Neglect, Resident Rights, Monitoring Signs of Possible Elopement Risk. It included 26 staff signatures.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Castle Hills Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8020 Blanco Rd San Antonio, TX 78216	
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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of the facility's Wandering, And Elopement policy revised March 2019, revealed: if identified as at risk for wandering, elopement or other safety issues, the residents care plan will include strategies and interventions to maintain the resident's safety. 2.) if an employee observes a resident leaving . attempt to prevent; Request assistance from other staff; Instruct another staff member to alert management 3.) if a resident is missing, initiate the elopement/missing resident emergency procedure: a determine if the resident is out on an unauthorized leave of absence; b.) if the resident was not on an unauthorized leave, initiate a search of the facility, grounds and immediate area surrounding the building; c.) if the resident is not in any of the searched areas notify the administrator, director of nursing, family/responsible party and law enforcement officials.</p> <p>Record review of In-Service training report dated 3/20/2024 on the topic of Alerts and Meaning; Contents or summary of training . Code green - missing residents. This training was conducted by the DON and included signatures of 22 staff members.</p> <p>The facility's Plan of Removal was accepted on 03/23/2024 at 7:51 A.M. and included:</p> <p>F600- Immediate Action</p> <p>Notify The Medical Director of the Immediate Jeopardy status.</p> <p>Resident # 1 and Resident #2 are no longer residing at the facility.</p> <p>The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified.</p> <p>Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 10 pm on 03/22/2024.</p> <p>Alarm was installed on the dining room door to the front office, which contains the outside exit door.</p> <p>The alarm is turned on nightly as the receptionist leaves at 8:00 pm by the Charge Nurse. The alarm will remain off during daytime hours when the front office area is monitored by the receptionist.</p> <p>The charge nurse will check the alarm and door every two hours to ensure they are on and functioning.</p> <p>The alarm will remain turned on throughout the weekend.</p> <p>The alarm checks will be documented on a log included with the abatement plan.</p> <p>Training on the door alarm will be completed by Sunday, 03/24/24, at noon.</p> <p>Inservice staff on elopement/missing resident protocols, which includes color-coded announcements and search areas.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>For new admissions, when staff conduct routine checks, they will discuss with residents the resident's comfort, orientation, and understanding of facility rules, such as the process to check out when going on pass. These conversations will be in addition to the orientation provided by the admitting charge nurse.</p> <p>The charge nurse will turn on the front door alarm after the receptionist leaves - no later than 8:00 p.m.-and document the action on a check log. Staff will be in service to answer door alarms after the start of the new process and quarterly thereafter.</p> <p>The Clinical Liaison and Marketer and the Admissions Director/designee will carefully scan records to ensure residents are appropriate for facility services and will make residents aware of efforts to assist resident's plan for discharge. The Admissions Director/designee will review the procedures for signing in and out for a pass. For after-business-hours admissions, the nurse admitting the resident will cover these steps during the assessment and orientation process for the resident.</p> <p>The administrator and DON will provide education on the Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy, with a focus on the need to monitor residents going in and out of the dining room front door and monitoring the front door alarm. The target date for training completion is Sunday, 03/24/24, by noon.</p> <p>New employees and agency nurses (if used) will be educated on the alarms and resident monitoring during orientation and before starting their initial shift.</p> <p>An interview with LVN A on 3/23/24 at 245 p.m. confirmed that she was in-serviced and educated on the alarms and resident monitoring. Before starting her shift on 3/22/23 at 9:30 P.M. by the DON.</p> <p>The Administrator and Director of Nurses will educate the Clinical Liaison and the Admissions Director on reviewing referral paperwork and on the importance of identifying information that may need to be reviewed by the Director of Nursing before acceptance. This will ensure that residents accepted for admission are appropriate for the facility and do not require a secured facility. Residents deemed unsafe for admission due to wandering behaviors will not be admitted . Training will be completed by Sunday, 03/24/24, at noon.</p> <p>Upon admission, the Admissions Director and/ or designee will discuss facility rules with the resident and responsible party regarding signing in and out to go on pass. The charge nurse admitting the resident will further discuss the facility rules for exiting the facility and will assess the elopement risk of the new resident. If it is determined at any time post-admission that a resident is no longer safe and needs a secured unit, the resident will have 1:1 monitoring until safely discharged to an appropriate facility. Education will be provided on this process to the Department Managers, including the Admission Director and Clinical Liaison, as well as the Charge Nurses and Nurse Managers. This training will be completed by the Administrator and the Director of Nurses by Sunday, 03/24/24, at noon.</p> <p>The DON and/ or designee will audit all new admissions and readmissions daily to ensure an elopement risk assessment has been completed and that the resident has been provided with orientation for the out-on-pass procedure.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Director of Nurses and/ or designee will complete and review elopement risk audits with each admission, readmission, and change of condition. Quarterly assessments and reviews will remain ongoing to ensure that an appropriate and personalized plan of care is in place for residents at risk and that compliance and standards are met.</p> <p>The administrator and director of nurses will provide the staff with training on Elopement Protocols by Sunday, 03/24/24, at noon.</p> <p>If an employee observes a resident leaving the premises, he/she should:</p> <ol style="list-style-type: none"> Attempt to prevent the resident from leaving in a non-threatening, courteous manner. Request assistance from other staff member in the immediate vicinity as needed. Instruct another staff member to alert the charge nurse, Director of Nursing and/or Administrator of the resident's intent to leave the premises. <p>If a resident is missing, initiate the elopement/missing resident emergency procedure:</p> <ol style="list-style-type: none"> Determine if the resident is out on an unauthorized leave of absence. If the resident was not authorized to leave, initiate a search of the facility, grounds, and immediate areas surrounding the building. If the resident is not in the searched areas, notify the Administrator, the Director of Nursing, the family/responsible party, and law enforcement officials. <p>When the resident returns to the facility, the director of nursing services or charge nurse shall:</p> <ol style="list-style-type: none"> Notify staff and examine the resident for injuries. Notify the physician and medical director of the resident return and assessment findings. Notify the family/ responsible party. <p>Verification included:</p> <p>Notify The Medical Director of the Immediate Jeopardy status.</p> <p>Verified via interview with Medical Director [Name of MD], on 3/23/24 at 1:12 PM, she was notified of the IJ at on 3/22/24 at 6:45 PM.</p> <p>Resident # 1 and Resident #2 are no longer residing at the facility.</p> <p>Verified, via interview with The DON on 3/23/24 at 1:24 P.M., that Resident # 1 was discharged from the facility on 3/20/24 at 107 P.M., and Resident # 2 was discharged from the facility on 3/19/24 at 10:00 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Director of Nurses and Assistant Director of Nurses are completing Elopement Assessments on all current residents to ensure the risk category is accurately identified.</p> <p>Verified, Elopement assessments completed on electronic medical records for 49 of 49 residents.</p> <p>Residents identified as high risk will be reported to the physician and IDT to determine appropriate action and interventions. This task will be completed by 10 pm on 03/22/2024.</p> <p>Verified, on 3/23/24 via Interview with DON, that none of the 49 current residents were identified as High Risk.</p> <p>Alarm was installed on the dining room door to the front office, which contains the outside exit door.</p> <p>Verified by surveyor on 3/23/24 at 10:45 a.m. upon entrance that dining room door to front office is present and functioning.</p> <p>The alarm is turned on nightly as the receptionist leaves at 8:00 pm by the Charge Nurse. The alarm will remain off during daytime hours when the front office area is monitored by the receptionist.</p> <p>Verified, via an interview with The Administrator on 3/23/24 at 120 p.m., that the alarm is turned on by the receptionist nightly at 8:00 P.M. Verified that the alarm is monitored during daytime hours by the receptionist.</p> <p>Verified, via logbook noted on south wing of [name of Nursing Home] on 3/23/24 at 210 P.M that night shift nurses monitor alarm after 8:00 p.m.</p> <p>The charge nurse will check the alarm and door every two hours to ensure they are on and functioning.</p> <p>Verified, via log book signatures noted on south wing of [Name of Nursing Home] on 3/23/24 at 210 P.M that night shift nurses monitor alarm after 8:00 p.m.</p> <p>The alarm will remain turned on throughout the weekend.</p> <p>Verified, by surveyor on 3/23/24 at 10:45 a.m. upon entrance that alarm is on and functioning.</p> <p>The alarm checks will be documented on a log included with the abatement plan.</p> <p>Verified, via log book signatures noted on south wing of [name of Nursing Home] on 3/23/24 at 210 P.M .</p> <p>Training on the door alarm will be completed by Sunday, 03/24/24, at noon.</p> <p>Verified, completed training for Door alarms was completed by 54/54 employees, noted with signatures acknowledging in-service.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Inservice staff on elopement/missing resident protocols, which includes color-coded announcements and search areas.</p> <p>Verified, Inservice elopement/missing resident protocols staff signatures and interviews with the DON, ADON, and the Administrator revealed DON and ADON were trained step by step in elopement/missing resident protocols procedure on 03/22/23 to cover immediacy by the Administrator. DON and ADON were brought into the office, provided a copy of the procedure, and were able to verbalize understanding of the procedure. See the in-service sheets attached.</p> <p>For new admissions, when staff conduct routine checks, they will discuss with residents the resident's comfort, orientation, and understanding of facility rules, such as the process to check out when going on pass. These conversations will be in addition to the orientation provided by the admitting charge nurse.</p> <p>Verified, in-service elopement/missing resident protocols was completed via in-service elopement /missing resident protocols was completed by (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, and (2) 10 pm-0600 am LVN's.</p> <p>The charge nurse will turn on the front door alarm after the receptionist leaves - no later than 8:00 p.m.-and document the action on a check log. Staff will be in service to answer door alarms after the start of the new process and quarterly thereafter.</p> <p>Verified via in-service elopement /missing resident protocols was completed for: (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, (2) 10 pm-0600 am LVN's. and (2) receptionists.</p> <p>The Clinical Liaison and Marketer and the Admissions Director/designee will carefully scan records to ensure residents are appropriate for facility services and will make residents aware of efforts to assist resident's plan for discharge. The Admissions Director/designee will review the procedures for signing in and out for a pass. For after-business-hours admissions, the nurse admitting the resident will cover these steps during the assessment and orientation process for the resident.</p> <p>Verified, via in-service signature, elopement /missing resident protocols was completed by The Clinical Liaison, Marketer, and Admissions Director.</p> <p>Verified via in-service elopement /missing resident protocols was completed by (2) 6 am-2 pm LVN's, (2) 2 pm - 10 pm LVN's, (2) 10 pm-0600 am LVN's.</p> <p>The administrator and DON will provide education on the Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy, with a focus on the need to monitor residents going in and out of the dining room front door and monitoring the front door alarm. The target date for training completion is Sunday, 03/24/24, by noon.</p> <p>Verified, via record review of the in-service sheet Titled Wandering and Elopement Policy, Emergency Procedure-missing Resident Policy, and Abuse, Neglect, and Exploitation policy reflected 54 staff members' signatures. 11 LVNs, 2 RNs, 12 CMA's, 11 Administrative personnel, 10 Therapists, 3 housekeepers, and 6 dietary staff. 24 out of 54 staff members interviewed (8 LVN, 2 RN, 6 Therapy, 3 Administrative, 5 dietary) verified Inservice.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>New employees and agency nurses (if used) will be educated on the alarms and resident monitoring during orientation and before starting their initial shift.</p> <p>Verified via interview with the DON on 3/23/24 at 235 P.M. that no new licensed nurses have been hired since this IJ, and only one agency nurse has been used by the [Name of Nursing home] since the IJ.</p> <p>An interview with LVN A on 3/23/24 at 245 p.m. confirmed that she was in-serviced and educated on the alarms and resident monitoring. Before starting her shift on 3/22/23 at 9:30 P.M. by the DON.</p> <p>The Administrator and Director of Nurses will educate the Clinical Liaison and the Admissions Director on reviewing referral paperwork and on the importance of identifying information that may need to be reviewed by the Director of Nursing before acceptance. This will ensure that residents accepted for admission are appropriate for the facility and do not require a secured facility. Residents deemed unsafe for admission due to wandering behaviors will not be admitted . Training will be completed by Sunday, 03/24/24, at noon.</p> <p>Verified via interview with Clinical Liaison and Admissions Director on 3/23/24 at 245 pm that they were in-serviced on referral paperwork that may need to be reviewed by the Administrator and the DON.</p> <p>Upon admission, the Admissions Director and/ or designee will discuss facility rules with the resident and responsible party regarding signing in and out to go on pass. The charge nurse admitting the resident will further discuss the facility rules for exiting the facility and will assess the elopement risk of the new resident. If it is determined at any time post-admission that a resident is no longer safe and needs a secured unit, the resident will have 1:1 monitoring until safely discharged to an appropriate facility. Education will be provided on this process to the Department Managers, includin [TRUNCATED]</p>		