STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455510	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Castle Hills Rehabilitation and Care Center	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and supervision. The facility failed to supervise Resident #1 who eloped from the facility on 06/19/2024 and was found approximately 50 feet away from the facility at an intersection. This noncompliance was identified as past non-compliance. The past non-compliance IJ began on 06/19/2024 and ended on 06/23/2024. The facility had corrected the non-compliance before the survey began. This deficient practice could place residents who were elopement risks at-risk of harm, serious injury, or death. The findings included: A record review of Resident #1's admission record dated 08/02/2024 revealed Resident #1 was admitted on [DATE] with diagnoses which included hemiplegia (left sided semi paralysis), vascular dementia (brain damage caused by multiple strokes), and general anxiety disorder. A record review of Resident #1's quarterly MDS assessment dated [DATE] revealed Resident #1 was a [AGE] year-old male admitted for long term care and assessed with a BIMS score of 09 out of a possible 15 which indicated moderate cognitive impairment. Resident was assessed as using a manual wheelchair and was assessed as, Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity . Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's care plan dated 08/02/2024 revealed Resident #1 was an elopement risk and had a history of elopement 06/19/2024 . monitor Resident #1 for indications of elopement seeking, cigarette seeking . redirect to next smoke break, offer activities television, music, magazines, snacks . is/has potential to be verbally aggressive to staff and other residents r/t mental/emotional illness . assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. assess resident's coping skills and support system . give the resident as many choices as possible about care and activities . provide positive feedback for good behavior . emphasize the positive aspects of compliance . psychiatric/psychogeriatric consult as indicated . when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress, engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later A record review of Resident #1's medical record from 09/01/2023 to 08/02/2024 revealed Resident #1 was assessed on 03/23/2024 as a low wander elopement risk and on 06/19/2024 had an elopement incident. A record review of Resident #1's nursing notes revealed LVN A documented on 06/19/2024 at 01:34 AM, Resident #1 was seen in the smoking courtyard at approximately 09:50 PM and by 10:45 PM could not be located. LVN A documented she initiated the facility's elopement procedure and began an all-facility search, notified the DON, the Administrator, and the local police department, accounted for all other residents, and expanded the search to outside of the facility. LVN A documented while on the telephone with the DON the local police department called the facility at 11:28 PM to report they were supervising Resident #1 nearby the facility. During an interview on 08/01/2024 at 04:58 PM the DON stated on 06/19/2024 at 09:50 PM Resident #1 was seen by LVN A in the facilities smoke break area hyper focused on receiving another cigarette. The DON stated he had already smoked his cigarette, the last allotted for the day, and staff redirected him to other activities to have the Resident continue with his activities of daily life and prepare for bed. The DON stated by 10:45 it was recognized by LVN A that Resident #1 was not in the facility. The DON stated she and LVN A initiated the facility's elopement protocol and assigned staff responsibilities to simultaneously account for all residents, search the entire facility, alert the local police department, alert the DON, the Administrator, and expand the search to the exterior of the facility. They organized a staff lead vehicle assisted search of the surrounding neighborhood when the local police department called the facility and stated they were supervising Resident #1 who was alongside of the road by the facility. The DON stated she and the Administrator met the police officers and assumed custody of Resident #1 at 11:58 PM on 06/19/2024. The DON stated Resident #1 was located across the street from the facility about a block down the road and described the location on an internet-based map. The DON stated Resident #1 was returned to the facility and assessed without any injuries. The DON stated Resident #1's physician ordered bilateral knee x-rays which resulted negative for injuries. The DON stated Resident #1 received enhanced monitoring from a 1 to 1 staff member every 15 minutes for 6 hours. The DON stated the Administrator initiated an investigation. A record review of an internet-based map accessed on 08/02/2024 as described by the DON revealed Resident #1 was located approximately 688 feet from the facility's front door. The Administrator was notified on 08/02/24 at 06:00 PM, a past non-compliance IJ situation had been identified due to the above failure. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	It was determined the failures placed Resident #1 in an IJ situation on 06/19/2024. The facility implemented the following interventions. During a joint interview on 08/02/2024 at 04:00 PM the Administrator and the DON stated the facility had 2 exit doors commonly utilized by staff to enter and exit the facility. The DON stated one door was the front door which was monitored by the facility's receptionist from 06:00 AM to 08:00 PM and the other door was the back door which was secured with an electromagnet and released by a numeric coded keypad. The DON stated the front door also had an electromagnet and was secured from the hours of 08:00 PM to 06:00 AM. The Administrator stated the front door was secured by the receptionist when she left for the day, and he would receive a daily message alerting him to the practice of securing the front door. The Administrator stated on 06/20/2024 immediately after Resident #1's elopement the facility initiated an investigation, reported the incident to the state agency, assessed Resident #1 and concluded he had no injuries, assessed peer residents for safety and revealed all were safe without injuries, interviewed all staff on duty, and interviewed residents who may have witnessed Resident #1. It was concluded Resident #1 may have eloped through the facility's front door either by exiting concurrently when a staff or visitor entered or exited the facility or Resident #1 may have covertly gained knowledge of the code. The Administrator stated the facility reviewed the elopement incident and developed and implemented quality improvement initiatives which included monitoring the secured front doors and back door every 2 hours from 08:00 PM to 06:00 AM, changing the door codes every month, and replacing the alarm batteries every month. The DON stated Resident #1's care plan was updated by the interdisciplinary team to include enhanced monitoring of Resident #1 especially when he was agitated and became focused on finding cigarettes. The Administrator stated all staff were in-serviced on Resident #1's care plan, ANE prevention, elopement prevention, reporting allegations of ANE, and/or elopement. The DON stated Resident #1 has been assessed an elopement risk and has been added to the elopement binder located at the receptionist desk. A record review of the facility's elopement binder located at the receptionist desk revealed Resident #1 was identified as a wander elopement risk, should be redirected per his care plan, and staff were to communicate with each other to redirect Resident and/or initiate the elopement protocol with attempts to re-direct Resident #1 to safety. During an interview on 08/02/2024 at 01:15 PM Receptionist E stated she was the receptionist from 06:00AM to 02:00 PM or sometimes from 08:00 PM to 06:00 PM. Receptionist E stated the front door was monitored from 06:00 AM to 08:00 PM and if she was not there, other staff (the BOM, the Administrator, etc.) would monitor the front door from 06:00 to 08:00 AM when she arrived or from 06:00 PM to 0:0 PM when she left. Receptionist E stated she had access to the facility elopement binder located at the desk and identified Resident #1 with specific interventions to re-direct Resident #1 away from the front door. A record review of the facility's daily front door and back door monitor logs revealed the doors had been checked every 2 hours from 08:00 PM to 06:00 PM since 06/21/2024. A record review of the facility's employee roster dated 08/01/2024 revealed 73 employees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the facility's in-service records dated 06/20/2024, 06/21/2024, and 06/23/2024 revealed 63 employees across all departments and work shifts had signed and documented they received the re-enforced trainings for elopement protocol and reporting, ANE prevention and reporting, and resident #1's care plan to include re-direction interventions when he was becoming agitated and cigarette seeking. During an interview on 08/01/2024 at 5:01 PM LVN A stated she had received the elopement protocol, Resident #1's care plan, and ANE prevention and reporting in-service sometime at the end of June 2024. LVN A stated she recalled the DON ensured everyone received the in-services. During an interview on 08/02/2024 at 01:45 PM LVN B stated she worked all shifts and usually worked the 06:00 AM to 02:00 PM shift. LVN B stated she recalled everyone received in-services regarding Resident #1's elopement in June 2024. LVN B stated she would and had redirected Resident #1 when he became fixated on receiving a cigarette and Resident #1 forgets he just had a smoke break. LVN B stated it was a group effort with staff coordinating and providing Resident #1 with alternatives such as an activity, he likes bingo. During an interview on 08/02/2024 at 02:10 PM LVN C stated she had just started and had received in-service training to include Resident #1's care plan and ANE and elopement prevention protocols. LVN C stated she usually worked the 02:00 PM to 06:00 PM shifts and has been assigned to ensure the front door has been secured after 08:00 PM and to check on Resident #1 often. During an interview on 07/31/2024 at 11:20 AM CNA D stated he has worked with Resident #1 and has received training to redirect Resident #1 when he becomes aggressive with cigarette seeking. CNA D stated he would offer the Resident with assistance with the toilet or offer clothing change. CNA D stated he usually does not work with Resident #1 but had provided care for the Resident occasionally. CNA D stated, if he's soiled, he lets me change him, and he forgets about the cigarette. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of the facility's in-service records dated 06/20 through 06/23/2024 revealed policies which included: Emergency Procedure - Missing Resident dated 2018, the policy statement resident elopement resulting in a missing resident is considered a facility emergency . residents at risk for wandering and for elopement will be monitored, and staff will take necessary precautions to ensure their safety . staff will implement the protocol for missing resident immediately upon discovering that a resident cannot be located. Emergency procedure missing Resident . announce president missing using facility code, note the time the resident was discovered missing, notify the Administrator, director of maintenance, director of nursing. Initiate a thorough search by staff members to locate the Resident. Instruct staff members to search the entire facility, grounds and neighboring street. Assign each staff member an area to search to avoid overlap. Look under bed, furniture, clothing closet, and behind doors . staff will report search results to the Administrator . if the search is unsuccessful, the administrator will contact the police to report the missing result Wandering and elopement policy . the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. As at risk for wandering, elopement, or other safety issues, the residents care plan will include strategies and interventions to maintain the residence safety. If an employee observes a resident leaving the premises, he or she should: attempt to prevent the resident from leaving in a non-threatening courteous manner, request assistance from other staff members in the immediate vicinity as needed, instructed another staff member to alert the charge nurse, director of nursing and or administrator of the residents' intent to leave the premises . if a resident is missing, initiate the elopement missing resident emergency procedure: