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	09/12/2025

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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent elopement for 1 of 15 residents (Resident#74) reviewed for accident hazards and supervision. Resident #74 eloped at night and crossed a busy 5-lane road before she was found at a bus stop by an off-duty CNA. This failure resulted in the identification of an IJ (Immediate Jeopardy) on 09/10/25. While the immediacy was removed on 09/12/25, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to monitor the implementation and effectiveness of its Plan of Removal This failure could place residents at risk for elopement, significant injury, and serious impairment or death.The Findings included:Observation on 9/9/25 from 8:50 AM to 10:15 AM of facility reflected: the inside door to the front lobby had a charm and keypad; the charm sounded when the door was opened. The door had an old wandering alert system not working and an electronic magnetic lock not working. The front door of the facility had no charm and/or keypad system or 15 second delay system; the front door was locked by a dead bolt. Receptionist desk was adjacent to the front door. Receptionist was present at the receptionist desk. Further observation of the path Resident #1 took during the elopement incident reflected the bus stop was about 150 feet from the facility. The bus stop was off the facility's ground and a 5-lane highway with busy traffic was adjacent to the bus stop. The resident had to cross the 5-lane road to get to the bus stop. Record review of Resident #74's face sheet, dated 9/10/25, reflected a 75 -year-old female who was admitted to the facility on [DATE] for respite care and discharged [DATE]. Resident #74 had diagnoses which included: HTN (hypertension), dementia (brain disorder resulting in decline in cognition), Alzheimer's disease (progressive disease that destroys memory), and breast cancer. The RP was listed as a family member. Record review of Resident's MDS, dated [DATE] in progress, reflected the resident's BIMS score was zero indicative of severe impairment in cognition. Resident was ambulatory. Record review of facility's incident report dated 9/6/25 titled Elopement Attempt Report, Resident #74, reflected: the timeline of elopement, namely between 8:59 PM and 10:08 PM. Further, the interview the Administrator had with the resident at 9/7/25 at 9:45 AM, the resident communicated to the Administrator she looked for an opportunity to elope and did not want to remain in the facility and wanted to visit her sister. The resident stated her work was done and she did not need to occupy a bed of another patient. Record review of Resident #74's Ambulation Assessment, dated 9/3/25, reflected resident was ambulatory. Record review of Care Plan dated 9/3/25 (baseline) read: .Assess for risk of elopement.Frequent rounding of resident. Record review of Resident #74 elopement score, dated 9/3/25 was 7 (moderate risk) [3-7score equaled moderate risk for elopement] Record review of Resident #74's Nurse Note, dated 9/6/25, at 8:58 PM authored by RN E reflected resident was seen wandering throughout the facility. Record revies of Resident #74's Nurse Note dated 9/6/25 at 10:33 PM authored by RN E read, .CNA [D] reports to this nurse [RN E], resident noted at bus stop across the street from facility. Brought resident back in with him. Resident confused; states she is trying to find her sister. Resident denies being hurt or any pain. Respiration even. Skin warm and dry. Skin assessment clear, no issues. [vitals]116/74 [blood pressure]62 [pulse] 18 [respiration] 97.8 [temperature] 96% [O2]Room Air Assisted to room and into bed. No acute distress noted. Call placed and message left for RP. Record review of facility's Elopement Binder, undated, found at the receptionist's desk reflected the presence of 15 face sheets with photographs. Resident #74 's face sheet and photo were in the binder. Record review of receptionist's written statement undated reflected she left the receptionist station around 9:40 PM to purchase dinner at a nearby restaurant. Receptionist stated she did not turn on the foyer alarm at 8:00 PM and she could not recall setting the alarm at 10:00 PM. During an interview on 9/9/25 at 10:10 AM the Maintenance Director, who accompanied the survey on Resident #74's route of elopement, stated he could not explain why the inside door charm was not heard and the keypad not set after 8:00 PM. The Maintenance Director stated the facility did not have a patient alert system. The Maintenance Director stated the distance to the bus stop was about 150 feet from the facility. The Maintenance Director stated it was a negative incident for a resident to wander to the bus stop because of the dangers of traffic, accidents and hazards, and stray dogs. The Maintenance Director stated the last time he checked the door alarm system was 8/25/25 and there were no concerns and he checked the alarm system weekly. During an interview on 9/9/25 at 11:05 AM, the DON stated Resident #74 was discharged on 9/8/25 around 5 PM because she needed to be in an environment that she was more