STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455533	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Nursing and Rehabilitation	8800 Fourwinds Dr San Antonio, TX 78239

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 1 of 2 residents (Resident #3) reviewed for quality of care. Resident #3 exited the facility through an alarming secure unit exit door on 5/14/2025. CNA A turned off the alarm without looking for Resident #3. Resident #3 left the facility and went missing for over 1.75 hours. The police found Resident #3 in a parking lot near an interstate highway and highway access roads. The noncompliance was identified as PNC. The IJ began on 5/14/2025 and ended on 6/4/25. The facility had corrected the noncompliance before this investigation survey began. This failure could place residents at risk of injury or death due to lack of supervision. The findings were: Record review of Resident #3's face sheet, dated 7.29.25, and EMR (electronic medical record) revealed the resident was admitted on 4.18.25 with diagnoses that included: ALZHEIMER'S DISEASE WITH LATE ONSET, insomnia, dementia, depression, and anxiety. The RP (responsible party) was a family member. Record review of Resident #3's quarterly MDS assessment, dated 5.1.25, revealed,BIMS score was 4 (0-5=severe cognitive impairment)ADLs: B/B was frequently incontinent requiring substantial/maximal supervision. Transfer independent. Bed Mobility was independent. ROM showed no impairment.Section P - Restraints and Alarms, revealed that bed/chair/out of bed restraints and alarms were not in use. Record review of Resident #3's Care Plan, dated 5.19.25, revealed the resident was a high elopement risk/wanderer, disoriented to place, with a history of attempts to leave the facility unattended, and impaired safety awareness. The goals were: the resident's safety will be maintained through the review date and the resident will not leave facility unattended through the review date. Interventions included: Document wandering behavior and attempted diversional interventions in behavior. For night shift, resident is on 1:1 visual monitoring. Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures, and memory boxes. Room change away from back door. The resident's triggers for wandering/eloping are (early morning and sun downing hours). The resident's behavior was de-escalated by redirecting him away from door and offering pleasant diversions, structured activities, food, conversation, television, book, and magazines. Record review of Resident #3's Wandering Risk Scale showed a score of 13 (High Risk Wanderer) on 5.14. 25, a score of 14 (High Risk Wanderer) on 4.21.25, and a score of 13 (High Risk Wanderer) on 4.18.25. Record review of Resident #3's orders revealed he had an order from 4.20.25 stating he should reside on the secure unit due to wandering and high risk of elopement. Record review of Resident #3's Nurse Note, dated 5.14.25 and created at 7:23 AM, authored by LVN B, revealed CNA A notified him that the C-back alarm was set off while she was on another unit and that Resident #3 could not be found. LVN B began searching all rooms with available CNA staff and initiated a code purple. DON assisted with the search, called emergency services, and notified the ADMIN. All available staff were searching possible areas. The DON notified the RP. Record review of Resident #3's Nurse Note, dated 5.14.25 and created at 11:55 AM, authored by the DON, revealed he was notified by charge nurse LVN B that floor staff has been unable to locate Resident #3 and all current members of staff on unit C continue to look for him. The DON assisted the search. After 5 minutes of looking for the resident, a code purple was called, and the entire team began looking for the resident on and off the property. The DON called the ADMIN and informed her of the elopement. The DON called 911 at 6:50 AM. A resident flyer with personal information was copied for police and staff members. Record review of Resident #3's Nurse Note, dated 5.14.25 and created at 12:02 AM, authored by DON, revealed Resident #3 was located and brought back to the facility by the police department. He received a full head to toe assessment. Skin noted to be intact with no bruises, scrapes, or bumps noted. A neurological assessment remains at baseline. DR G was informed of the elopement and safe return with no new orders obtained. Resident placed on line-of-site (sic) monitoring to prevent reoccurrence. Nursing staff received updates and in-service training. Record review of Resident #3's Nurse Note, dated 5.14.25 and created at 12:59 PM, authored by charge nurse LVN C, revealed Resident #3 was located and brought back to the facility by the police department. A full head to toe assessment was completed. Skin noted to be intact with no bruises, scrapes, or bumps noted. A neurological assessment remains at baseline. The resident denies pain or discomfort. The RP was notified of Resident #3's return and bed change to a room closer to the nurse's station. No new orders from the NP and per the DON, the resident was placed on line-of-site (sic) monitoring and neuro checks for 72 hours. Record review of Resident #3's Nurse Note, dated 5.15.25 and created at 6:48 AM, authored by LVN B, revealed staff was on 1-to-1 monitoring and 30-minute visual checks