STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455599	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehabilitation and Skilled Nursing C	2806 Real St Austin, TX 78722

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure that all alleged violations were reported immediately or not later than 24 hours for 1 (Resident #1) of 6 residents reviewed for elopement. The facility failed to report to the SA an incident where Resident #1 eloped from the facility on 11/01/24. This deficient practice could place residents at risk of abuse, neglect, elopement, injury, and death. Findings included: Review of Resident #1's admission record, dated 11/06/24, reflected she was a [AGE] year old female who initially admitted to the facility on [DATE], readmitted on [DATE], was discharged to the hospital on 11/01/24, had an RP, and had diagnoses including cerebral infarction due to embolism of left middle cerebral artery (a medical condition that occurs when an embolism blocks blood flow to the middle cerebral artery, resulting in an ischemic stroke), essential (primary) hypertension (a common condition that occurs when the pressure of your blood is consistently too high), aphasia (a language disorder that makes it difficult to understand, speak, read, or write), flaccid hemiplegia affecting left dominant side (a condition that causes paralysis in the left side of the body, making it difficult or impossible to move), hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side (a condition that occurs when a stroke or other brain injury damages the right side of the brain, causing weakness or paralysis on one side of the body), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), unspecified anxiety disorder, muscle wasting and atrophy (terms for the loss of muscle tissue and strength), other abnormalities of gait and mobility, other lack of coordination, and need for assistance with personal care. Review of Resident #1's comprehensive MDS assessment, dated 10/29/24, reflected no BIMS indicated, no wandering behaviors exhibited, no wander/elopement alarms used, and required supervision with walking. Review of Resident #1's BIMS assessment, dated 10/28/24, reflected staff couldn't conduct a BIMS evaluation because Resident #1 was rarely/never understood. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan, closed 11/06/24, reflected Resident #1 used anti-anxiety medications related to adjustment issues. Staff were required to monitor, document, and report PRN any adverse reactions to anti-anxiety therapy, such as unexpected side effects, including mania, hostility, rage, aggressive or impulsive behavior, and hallucinations. Resident #1's care plan also reflected that she had a behavior problem where she got agitated and broke the window related to visual hallucination of someone trying to get in her room through the window. Resident #1 was also noted breaking a window and exiting the facility, staff followed her, was able to locate her, and transferred her to the hospital related to a diagnosis of schizophrenia on 11/01/24. Staff were required to administer medications as ordered, monitor and document for side effects and effectiveness, discuss Resident #1's behavior if reasonable and explain/reinforce why behavior was inappropriate and/or unacceptable to the resident, praise any indication of Resident #1's progress/improvement in behavior, and provide a program of activities that is of interest and accommodates Resident #1's status. Resident #1's care plan also reflected she had a communication problem related to cerebrovascular accident (stroke). Review of Resident #1's progress notes, from 10/07/24 through 11/07/24, reflected, -A note by LVN B on 11/01/24 at 5:48 AM, which stated, At approximately 3:20 AM; resident broke her window and left running. Resident left running down [NAME] ave. CNA tried to follow resident down [NAME] ave but lost sight of resident and unable to find resident. Police was called, ADON and management was contacted. CNAs started driving around to see if they can find resident. Police officers were given a description of resident wearing a green long sleeve shirt with camouflage pants, possibly no shoes. Called RP left a message called again spoke with RP at 4:20 AM also called resident's familyat approximately 3:50 AM; he states he plans on searching for resident too. Multiples management currently searching for resident. this writer double checked around the outside of the facility. Also staff members check residents rooms. -A note by LVN B on 11/01/24 at 6:49 AM, which stated, At approximately 2:30 AM resident was sleeping in bed. -A note by LVN C on 11/01/24 at 7:00 AM, which stated, Resident RP notified that staff did find [Resident #1] running up MLK street but refused staff assistances or come to facility. Resident entered coffee shop where staff remained with her until EMS/Police arrival. Transported by EMS to Hospital. -A note by LVN B on 11/01/24 at 7:59 AM, which stated, At 4:42 AM; On-Call provider NP was notified of resident leaving facility and police being notified also of multiple staff looking for resident. -A note by LVN B on 11/01/24 at 9:35 AM, which stated, Resident was located by staff about 2 blocks from facility, as she saw the staff members, she went into a coffee shop where she stayed sitting down. Staff remained outside monitored resident through window and securing exit doors. Barista came outside and stated the resident appeared to get more agitated when she saw the staff. EMS and police was activated. Resident was taken to hospital in 4-point restraint and multiple seat belts as she was refusing to go to the hospital. Per staff report, resident refused EMS assessment and became very agitated when asked to roll up sleeves. Review of Resident #1's admission wandering evaluation, dated 10/22/24, reflected she had no history of wandering/elopement and was not a wandering risk. There were no wandering reevaluations in Resident #1's assessments. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation file for Resident #1's incident on 11/01/24 reflected on 11/01/24, ADON reviewed residents at risk for elopement, IDT reviewed Resident #1's chart to determine timeline of events for investigation process, staff were interviewed regarding if they seen anyone trying to leave the facility and none were identified, nursing, dietary, housekeeping and activities staff were reeducated on elopement procedure, broken window was monitored until maintenance repaired it, maintenance inspected the facility windows and no issues were noted, and all exit door codes were changed. Resident #1's self-inflicted injury incident, dated 11/01/24, reflected, At approximately 2:30 AM, resident was sleeping in bed. At approximately 3:20 AM; This writer heard a loud noise of glass breaking. This writer ran to resident room and CNA went to the front of the building. This write did not see resident in the room and noticed the broken window. When this writer went outside this writer saw all the broken glass. A staff member which was sitting outside in the front porch of the building she heard the rash of the glass and saw the resident jump out the window and started running down the street and she and a CNA started to ran after resident. This nurse returned to the building and called the police, description was provided, also called management. She was wearing a green blouse and camouflage pants and no shoes. CNA followed resident in the direction she was traveling, she then outran them, and he lost sight of her momentarily, however, other staff were dispatched to assist with the situation and search sorrowing area. Resident was traveling west and staff came down heading east. When the resident saw staff she ran into a coffee shop. Staff stayed monitoring resident through coffee shop window and also secured the exit doors. Barista stepped outside and informed the staff that the resident appeared to not want the staff inside the coffee shop. He went back inside and provided the resident with coffee and water as she sat at the coffee bar. EMS and police were activated. Up on arrival, 2 police officers and 2 EMS attendants restrained resident to the stretcher for transport to the hospital. Staff on sight noticed resident refused assessment by EMS. Resident out of facility. RN E wrote a statement, undated, and stated, I was contacted via telephone by ADON A regarding assistance with a resident that broke a window and left the facility. The nurse stated she was behind resident heading west towards downtown area on the street. Immediately headed towards that direction in my vehicle. Resident was spotted on the street heading to coffee shop. I followed resident in my vehicle and parked my care when I noticed resident going into the coffee shop. On arrival, [ADON A] was present. EMS and police department were on their way. We waited outside the coffee shop until they arrived. ADON A wrote a statement, undated, and stated, I received a call from the staffing ADON around 3:36 AM on 11/01/24 regarding a resident that broke the window, run away from the building but followed by staff. I immediately headed to the location of the resident and spotted her in abandon building in MLK close to the facility. It was too dark around the area; I did not get close to her because I didn't want her to run. I kept in contact with co-workers around the area. When my co-worker came, she walked faster heading [NAME] of the street as she was running from us until she reached the coffee shop. It appeared like she had seen me following her. We stayed outside of the coffee shop monitoring her through the window and keeping exit doors safe. All of the staff posted on the perimeter arrived at the coffee shop to assist. LVN B wrote a statement, dated 11/01/24, and stated, At approximately 2:30 AM resident was sleeping in bed. At approximately 3:20 AM; I heard a loud noise of glass breaking. This writer ran to resident room and CNA went to the front of the building. I did not see resident in the room and noticed the broken window. When I went outside I saw all the broken glass. A staff member which was sitting outside said resident jump out the window and started running down [NAME] ave and CNA had ran after resident. CNA lost sight momentarily due to her already too far away. Both staff members stated the resident was wearing a green long sleeve shirt with camouflage pants, CNA said it looked like she possibly did not have shoes on. Police was called and given a description of resident also Management was called. 2 CNAs were driving around the area to see if they can spot resident. Also one C.N.A. and a nurse followed the resident on foot. Staff were told to no approach resident by them self's due to resident behavior to call for help if they see resident. I walked around the building to double check if resident had returned and also I and other staff members check all residents rooms in the facility. Nurse received a call from treatment nurse that she had spotted the resident and the resident ran into a coffee shop, and that all other staff arrived at the coffee shop to assist with resident. CNA F wrote a statement, undated, and stated, I was on my break, sitting outside the main entrance when I heard continuous banging by a window to the left, at 3:15 AM. I was on my way back into the building, when I heard a crash of glass and saw a female jump out of the window

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to aphasia secondary to cerebrovascular accident (stroke). Resident unable to communicate frustration/fear of persecution. IDT determined not reportable based on provider letter content. Elopement protocol/procedure re-education with staff initiated. Review of the facility's abuse and neglect investigations for the last 3 months, from 09/01/24 through 11/06/24, reflected there was no self-reports related to Resident #1's 11/01/24 incident (elopement). During an interview on 11/06/24 at 10:03 AM, the DON stated on 10/31/24 or 11/01/24 at around 3:00 AM, Resident #1 broke her window and left the facility. The DON stated she didn't know why Resident #1 broke the window. The DON stated she was not working and at the facility when Resident #1 broke her window and left the facility. The DON stated LVN H and CNA I saw Resident #1 and followed her to a coffee shop. The DON stated there were also staff in their cars who followed Resident #1. The DON stated she didn't know how long the LVN H and CNA I followed Resident #1 because she wasn't working and at the facility when the incident happened. The DON stated she answered her phone on 11/01/24 at around 4:00 AM. The DON stated the ADM handled and managed Resident #1's incident. An attempt to contact Resident #1 was made on 11/06/24 at 10:15 AM. A voicemail and call back number was left. Resident #1 didn't return the call before exit. An attempt to contact Resident #1's RP was made on 11/06/24 at 10:17 AM. A voicemail and call back number was left. Resident #1's RP didn't return the call before exit. An attempt to contact Resident #1's family was made on 11/06/24 at 10:17 AM. A voicemail and call back number was left. Resident #1's family didn't return the call before exit. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 10:25 AM, the ADM stated on 11/01/24 in the early morning, Resident #1 broke the window. The ADM stated ADON J, who was notified by LVN B, who was notified by CNA I that CNA I heard glass and observed Resident #1 climbing out the window. The ADM stated the nurse who was outside also observed Resident #1 climb out the window. The ADM stated Resident #1 outran staff and disappeared passed the funeral home. The ADM stated staff conducted a call tree and were unable to locate Resident #1 until an hour later. The ADM stated Resident #1 was found on MLK drive in her panties and shirt. The ADM stated RN E observed Resident #1 running into traffic and into a 24-hour coffee shop. The ADM stated staff held Resident #1 at the coffee shop. The ADM stated staff notified the police department and EMS. The ADM stated Resident #1 told him that she broke the window because she was afraid. The ADM stated he didn't get to interview Resident #1. The ADM stated the ST and IDT interviewed Resident #1, who just wrote scary on a piece of paper. The ADM stated he didn't know when the ST and IDT interviewed Resident #1. The ADM stated he didn't report Resident #1's incident to the SA because it didn't meet the reporting criteria and because Resident #1 was seen leaving, staff knew where [NAME] went, and never stopped looking for [NAME] despite not finding her for one hour. The ADM stated Resident #1 didn't elope from the facility, had a psychotic break, had a case of psychosis, and her incident didn't meet the definition of elopement. The ADM stated had he felt it was a reportable incident, he would've called it in to the SA, but the fact staff saw Resident #1 leave, reviewed the incident, met with QAPI, looked at multiple areas, and did an investigation and timeline, he believed it wasn't reportable and that staff responded appropriately. The ADM stated to report elopement, it would be within 24 hours or immediately and if it involved serious injury. The ADM stated that according to the latest provider letter, the facility had 24 hours to report an elopement incident. The ADM stated residents couldn't be impacted if an incident was not reported to the SA. The ADM stated he didn't consider Resident #1 to be a missing resident during her incident. Review of the facility's incident log, from 08/06/24 through 11/06/24, reflected Resident #1's self-inflicted incident happened on 11/01/24 at 3:20 AM. An attempt to contact LVN C was made on 11/06/24 at 10:59 AM. A voicemail and call back number was left. LVN C didn't return the call before exit. During an interview on 11/06/24 at 11:31 AM, NA L stated he didn't work on 11/01/24. NA L stated if a resident was not in their room and he didn't know where the resident was, he would notify a charge nurse. NA L stated if the charge nurse didn't know where the resident was, he would look for the resident. NA L stated a resident was missing if he cannot find the resident after 24 hours. NA L stated he would report to a charge nurse if he suspected a resident was missing. NA L stated a resident who was missing was considered elopement if the resident was observed going through a window and disappeared from the road. NA L stated the ADM was responsible for reporting incidents to the SA. NA L stated if staff didn't report elopement to the SA, he didn't know what could happen to the resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/24 at 11:54 AM, CNA I stated he worked on 11/01/24 from 10:00 PM through 6:00 PM. CNA I stated he took a break on 11/01/24 at 3:30 AM in the clock room and heard a noise that sounded like glass break. CNA I stated he went outside because he thought someone broke a car glass window and saw Resident #1 run towards the MLK street. CNA I stated a new female CNA with an unknown name was outside before he was outside. CNA I stated he and the new CNA went back inside and notified LVN B that Resident #1 ran. CNA I stated LVN B came outside with him and the new CNA and he, the new CNA and LVN B ran to MLK street, but they couldn't find Resident #1. CNA I stated he came back inside, tried to get his car keys, went back outside, got in his car, and drove to MLK street to find Resident #1. CNA I stated he couldn't find Resident #1. CNA I stated he came back to facility, saw the ADM in front of the facility, and the ADM told him to drive again and find Resident #1. CNA I stated he still couldn't find Resident #1. CNA I stated he came back to the facility again and then went home because it was the end of his shift. CNA I stated he didn't know if staff found Resident #1. CNA I stated if resident goes missing, he was trained to look for the resident and notify the nurse. CNA I stated Resident #1's incident was elopement. CNA I stated Resident #1 was considered missing. CNA I stated he completed in-services on missing resident the same night on 11/01/24 and learned to report to the nurse if a resident was missing. CNA I stated the ADM was responsible for reporting incidents to the SA. CNA I stated if incidents were not reported by the ADM to the SA, residents could be abused. An attempt to contact LVN B was made on 11/06/24 at 12:20 PM. A voicemail and call back number was left. LVN B didn't return the call before exit. During an interview on 11/06/24 at 12:21 PM, CNA M stated she was not outside when Resident #1 broke the window on 11/01/24. CNA M stated she went outside around on 11/01/24 at around 2:00 AM and didn't see Resident #1 break the window and run away. CNA M stated she was given or signed any in-services. CNA M stated residents were considered eloped and missing if they broke a window, climbed through the window, ran down the street, and disappeared. CNA M stated Resident #1 was found four hours later on 11/01/24. CNA M stated nurses were responsible for reporting incidents to the SA. CNA M stated it was not good if incidents were not reported to the SA. During an interview on 11/06/24 at 1:18 PM, the NP stated her on-call NP was notified on 11/01/24 as soon as Resident #1's incident happened. The NP stated she reviewed notes from on-call NP and stated, The nurse reported that around 3:30 AM that patient [Resident #1] broke out window and escaped out of facility. She was last seen running towards apartment facility. Police and management had been notified. Nurse believed patient may have been hallucinating. The NP stated she thought Resident #1's incident was considered elopement because she escaped the facility. An attempt to interview RN E was made on 11/06/24 at 2:16 PM. A voicemail and call back number was left. RN E didn't return the call before exit. An attempt to interview ADON A was made on 11/06/24 at 2:17 PM. A voicemail and call back number was left. ADON A didn't return the call before exit. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/24 at 12:13 PM, the DON stated the facility didn't report Resident #1's incident to the SA because Resident #1 was within eyesight the entire time. The DON stated elopement meant if the resident was missing and the facility didn't have knowledge or supervision of the resident. The DON stated she received the call of staff following and finding Resident #1 on 11/01/24. The DON stated LVN B informed her about Resident #1's incident on 11/01/24. The DON stated her understanding was Resident #1 wasn't without eyesight and was within eyesight at all times. The DON stated Resident #1 sustained lacerations while she was out of the facility during the incident on 11/01/24. The DON stated the ADM was responsible for reporting incidents to the SA. The DON stated she didn't know what could happen to a resident if the ADM didn't report incident to the SA. During an interview on 11/07/24 at 1:01 PM, the CSM stated on 11/01/24 at around 6:00 AM-6:15 AM, Resident #1 came running into the coffee shop and pointed behind her. The CSM stated he believed Resident #1 pointed behind her as if someone was following her. The CSM he went outside the coffee shop believing someone was assaulting Resident #1 and didn't see anyone behind Resident #1. The CSM stated Resident #1 stayed inside the coffee shop for an hour. The CSM stated up to 10 staff were outside five minutes later and remained outside because Resident #1 was agitated and crying. The CSM stated he couldn't recall the police showing up and recalled observing two men from EMS. The CSM stated his understanding was Resident #1 broke a window and fled from the facility. An attempt to contact the police department's public information office was made on 11/07/24 at 1:19 PM and 1:22 PM. A voicemail and call back number was left. The police department's public information office didn't return the call before exit. Review of the facility's in-services and staff schedules, from 11/01/24 through 11/06/24, reflected LVN C, RN N, LVN B, CMA O, CMA P, CNA M, and CNA I were not in-serviced on elopement. Review of the facility's discharge report, from 08/06/24 through 11/06/24, reflected Resident #1 was discharged to the hospital on 11/01/24. Review of the facility's incidents and accidents policy and procedure, implemented 08/15/22, reflected, Policy: It is the policy of this facility for staff to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization. This can involve a visitor, vendor, or staff member. Policy Explanation: The purpose of incident reporting can include: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Missing Resident: Example of a missing resident: A resident is not in his room when staff wake residents up in the morning and the bed appears not to have been slept in. Staff search the facility and cannot find the resident.

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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** 47065 Based on observations, interviews, and record reviews, the facility failed to the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 6 residents reviewed for elopement. The facility failed to put interventions in place to prevent Resident #1 from eloping from the facility after she broke her window and attempted to leave through her window on 10/29/24. Resident #1 broke her window again and successfully eloped from the facility on 11/01/24. An IJ was identified on 11/06/24. The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on 11/08/24, the facility remained out of compliance at a scope of isolated and severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for unsafe elopements, injuries, and hospitalization . Findings included: Review of Resident #1's admission record, dated 11/06/24, reflected she was a [AGE] year old female who initially admitted to the facility on [DATE], readmitted on [DATE], was discharged to the hospital on 11/01/24, had an RP, and had diagnoses including cerebral infarction due to embolism of left middle cerebral artery (a medical condition that occurs when an embolism blocks blood flow to the middle cerebral artery, resulting in an ischemic stroke), essential (primary) hypertension (a common condition that occurs when the pressure of your blood is consistently too high), aphasia (a language disorder that makes it difficult to understand, speak, read, or write), flaccid hemiplegia affecting left dominant side (a condition that causes paralysis in the left side of the body, making it difficult or impossible to move), hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side (a condition that occurs when a stroke or other brain injury damages the right side of the brain, causing weakness or paralysis on one side of the body), chronic obstructive pulmonary disease (a common lung disease that makes it difficult to breathe), unspecified anxiety disorder, muscle wasting and atrophy (terms for the loss of muscle tissue and strength), other abnormalities of gait and mobility, other lack of coordination, and need for assistance with personal care. Review of Resident #1's comprehensive MDS assessment, dated 10/29/24, reflected no BIMS indicated, no wandering behaviors exhibited, no wander/elopement alarms used, and required supervision with walking. Review of Resident #1's BIMS assessment, dated 10/28/24, reflected staff couldn't conduct a BIMS evaluation because Resident #1 was rarely/never understood. (continued on next page)

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	455599	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehabilitation and Skilled Nursing C	2806 Real St Austin, TX 78722

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan, closed 11/06/24, reflected Resident #1 used anti-anxiety medications related to adjustment issues. Staff were required to monitor, document, and report PRN any adverse reactions to anti-anxiety therapy, such as unexpected side effects, including mania, hostility, rage, aggressive or impulsive behavior, and hallucinations. Resident #1's care plan also reflected that she had a behavior problem where she got agitated and broke the window related to visual hallucination of someone trying to get in her room through the window. Staff were required to administer medications as ordered, monitor and document for side effects and effectiveness, discuss Resident #1's behavior if reasonable and explain/reinforce why behavior was inappropriate and/or unacceptable to the resident, praise any indication of Resident #1's progress/improvement in behavior, and provide a program of activities that is of interest and accommodates Resident #1's status. Resident #1's care plan also reflected she had a communication problem related to cerebrovascular accident (stroke). Review of Resident #1's progress notes, from 10/07/24 through 11/07/24, reflected, -A note by LVN B on 10/29/24 at 3:14 AM, which stated, New admit day 7/7. Resident [Resident #1] was awake and going back and forth from dining area and her room multiple times at hour of sleep. This writer asked resident if she needed anything, if she was feeling okay. Resident nodded yes that she was okay and resident nodded yes on not feeling sleepy. No discomfort noticed. Resident returned back to her room at approximately 1:50 AM. -A note by LVN B on 10/29/24 at 7:22 AM, which stated, Heard glass braking at approximately 6:00 AM; this writer and other nursing staff started checking room to see if something was broken. Heard yelling coming from resident room. Resident was blocking the door from opening and yelling. This writer was able to coach resident to let nursing staff in the room. Once the door open resident immediately went to this writer and was bleeding from her left arm. Holding pressure to try to stop the bleeding. One cut is bleeding profusely on the left forearm which was wrapped with a pressure dressing. Called EMS due to the possibility of needing stitches. Did notice other small cuts on the left arm which weren't bleeding much. Staff members check resident room and outside resident room signs of any intruder none were seen. Nursing staff which was in the processes of coming in to shift change saw resident breaking the window. EMS took resident to hospital for evaluation for possible stitches. -A note by LVN B on 10/29/24 at 7:26 AM, which stated, Notified RP of resident going to hospital. Notified the NP of resident going to hospital. -A note by LVN C on 10/29/24 at 1:33 PM, which stated, Resident returned with no new orders from the hospital. -A note by LVN B on 10/30/24 at 1:56 AM, which stated, Resident up multiple times throughout the night. Continue to educate on safety and fall precautions. Will continue to monitor. -A note by LVN B on 10/30/24 at 6:27 AM, which stated, Resident went to sleep for around 2 hours then was again awake walking in hallway, and dining area. Watching TV in dining area. Resident continues to express fear this writer assure resident no one was going to break in to the facility. Assure resident that there are plenty of staff members here to keep her safe. Resident had her door open due to afraid of someone breaking in through the window. Resident also express pain to her eye and ear, resident express it had to do with the door but denies getting hit and denies bumping into the door. Resident also denies another person harming her. Gave PRN Acetaminophen. Also place medical fax for provider. Resident currently in dining area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A note by LVN C on 10/30/24 at 11:34 AM, which stated, Resident up in dining room area watching tv. Night shift report her being awake most of the shift and remain in dining room because she didn't want to be alone. -A note by LVN B on 10/31/24 at 3:01 AM, which stated, At 2:15 AM; heard crying from resident room. Resident had pushed bed away from wall and was searching for something on the floor. Resident was squeezing herself between there. Then resident showed this writer a picture of a little girl she got from the floor. Resident continued crying showing the picture to this writer. Noticed resident was stuck this writer helped resident out of between the wall and bedside. Resident was helped to dining area. The resident kept trying to show picture to this writer. From what this writer can assess no new injuries noticed. Resident refused full assessment. Resident kept pointing at her arm making a gesture of something biting her. This writer asked resident if something bite her she said no asked if she hurt her arm again resident first said yes then said no. Resident showing her left arm to this writer. This writer reminded resident she had a previous injury from the window glass resident first said yes then said no. This writer asked resident if she hurt her arm when she pushed the bed out resident first said yes than said no. This writer asked resident if this writer can check her vitals but resident refused. Resident currently in dining area in wheelchair. -A note by LVN B on 10/31/24 at 5:42 AM, which stated, Resident yelling out multiple times this morning started at approximately 5:00 AM. Resident would point at another resident and yell. This writer would assure resident that the other resident was okay. At approximately 5:30 AM resident was standing in the dining room bending down as if she was reaching for something and dangling her arms. This writer went to resident to remind resident of her weakness due to the stroke. Resident kept pointing at her arm this writer asked if it hurt resident said no this writer asked if resident if she couldn't move it like before resident nodded yes. This writer reminded resident of her being in the facility for rehab so she can recover from her recent stroke. Resident continues in dining area. -A note by LVN B on 10/31/24 at 6:05 AM, which stated, At approximately 5:50 AM; resident standing in front of back patio door and started doing back kicks. Resident did 5 back kicks to glass door. This writer and other staff were able to stop resident before damage to door. Resident went to back patio and sat herself onto the floor refusing to enter the building. Resident wanted to go home. Resident agreed come back in to facility and resident called family member. Called on-call provider NP to notify of resident behaviors. -A note by LVN C on 10/31/24 at 9:44 AM, which stated, Resident alert and oriented x 2 visited with boyfriend this morning, but still anxious/restless. Remain in dining room area with staff. -A note by LVN B on 10/31/24 at 1:37 PM, which stated, Resident has new orders melatonin 5mg q hs for insomnia, Ativan 0.5mg q 8 PRN for agitation/anxiety and psychiatrist evaluate/treat. RP notified. -A note by MA D on 10/31/24 at 9:35 PM, which stated, Melatonin Oral Tablet 5 MG Give 1 tablet by mouth at bedtime for insomnia. Note didn't mention anything about the refusal entry indicated in Resident #1's MAR/TAR for October 2024. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-A note by LVN B on 11/01/24 at 5:48 AM, which stated, At approximately 3:20 AM; resident broke her window and left running. Resident left running down the street. CNA tried to follow resident down the street but lost sight of resident and unable to find resident. Police was called, ADON and management was contacted. CNAs started driving around to see if they can find resident. Police officers were given a description of resident wearing a green long sleeve shirt with camouflage pants, possibly no shoes. Called RP left a message called again spoke with RP at 4:20 AM also called resident's at approximately 3:50 AM; he states he plans on searching for resident too. Multiples management currently searching for resident. this writer double checked around the outside of the facility. Also staff members check residents rooms. -A note by LVN B on 11/01/24 at 6:49 AM, which stated, At approximately 2:30 AM resident was sleeping in bed. -A note by LVN C on 11/01/24 at 7:00 AM, which stated, Resident RP notified that staff did find [Resident #1] running up the street but refused staff assistances or come to facility. Resident entered coffee shop where staff remained with her until EMS/Police arrival. Transported by EMS to Hospital. -A note by LVN B on 11/01/24 at 7:59 AM, which stated, At 4:42 AM; On-Call provider NP was notified of resident leaving facility and police being notified also of multiple staff looking for resident. -A note by LVN B on 11/01/24 at 9:35 AM, which stated, Resident was located by staff about 2 blocks from facility, as she saw the staff members, she went into a coffee shop where she stayed sitting down. Staff remained outside monitored resident through window and securing exit doors. Barista came outside and stated the resident appeared to get more agitated when she saw the staff. EMS and police was activated. Resident was taken to hospital in 4-point restraint and multiple seat belts as she was refusing to go to the hospital. Per staff report, resident refused EMS assessment and became very agitated when asked to roll up sleeves. Review of Resident #1's physician progress note, dated 10/31/24 and electronically signed by the NP on 11/02/24 at 11:49 PM, reflected the NP visited Resident #1 on a chief complaint related to following up on emergency room visit for anxiety and insomnia. The NP stated, On 10/29, patient [Resident #1] was transferred to the ER after she sustained a laceration with bleeding to the left forearm after she broke the window and tried to exit the building. In the ER, the laceration was approximated with steri-strip. CT head showed no acute changes. X-ray left forearm showed no foreign body. Patient was discharged back to the facility. Nurse reports that patient is very anxious and possibly hallucinating in the night and is not sleeping. Patient seen sitting on the wheel chair. She has expressive aphasia, but calm and cooperative and nods her head to yes or no questions. She denies any pain or discomfort. Left forearm laceration covered with Kerlix dressing. Nurse reports that patient is ambulatory but is impulsive and with unsteady gait. Will start on Ativan 0.5mg q 8 hours PRN anxiety and Melatonin 5mg q HS for insomnia. Will refer to psych services in house to eval and treat. Review of Resident #1's orders, dated 11/06/24, reflected Resident #1 was started on giving one tablet by mouth of 5 mg of Melatonin at bedtime on 10/31/24 at 8:00 PM and order ended on 11/02/24. Resident #1 was also started on giving one tablet by mouth of 0.5 mg of Ativan every eight hours as needed for anxiety/agitation for 30 days on 10/31/24 at 1:00 PM and order ended on 10/31/24 and started again on 10/31/24 at 1:30 PM and order ended 11/02/24. Resident #1 was also started on psychiatrist to evaluate and treat her one time only for five days on 10/31/24 at 1:15 PM and order ended on 10/31/24 and started again on 10/31/24 at 1:45 PM and order ended on 11/02/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's order summary report, dated 11/06/24, reflected, -Prescriber Written order for Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation for 30 Days ordered and started on 10/31/24 and ended on 11/30/24 -Prescriber Written order for Melatonin Oral Tablet 5 MG (Melatonin) Give 1 tablet by mouth at bedtime for insomnia ordered and started on 10/31/24 and no end date. -Prescriber Written order for psychiatrist to evaluate/treat one time only for five days ordered and started on 10/31/24 and ended on 11/05/24. Review of Resident #1's MAR/TAR schedule for October 2024 and November 2024 reflected Resident #1's administration entries for Ativan oral tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation for 30 Days were blank from 10/31/24 through 11/02/24. Resident #1's administration entries for Melatonin Oral Tablet 5 MG (Melatonin) Give 1 tablet by mouth at bedtime for insomnia indicated Resident #1 refused the tablet on 10/31/24 and it was blank on 11/01/24. Review of Resident #1's admission wandering evaluation, dated 10/22/24, reflected she had no history of wandering/elopement and was not a wandering risk. There were no wandering reevaluations in Resident #1's assessments. Review of Resident #1's plan of care, from 10/22/24 through 11/01/24, reflected Resident #1 exhibited wandering behavior and frequent crying on 10/30/24 at 9:59 PM. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's investigation file for Resident #1's incident on 11/01/24 reflected on 11/01/24, ADON reviewed residents at risk for elopement, IDT reviewed Resident #1's chart to determine timeline of events for investigation process, staff were interviewed regarding if they seen anyone trying to leave the facility and none were identified, nursing, dietary, housekeeping and activities staff were reeducated on elopement procedure, broken window was monitored until maintenance repaired it, maintenance inspected the facility windows and no issues were noted, and all exit door codes were changed. Resident #1's self-inflicted injury incident, dated 11/01/24, reflected, At approximately 2:30 AM, resident was sleeping in bed. At approximately 3:20 AM; This writer heard a loud noise of glass breaking. This writer ran to resident room and CNA went to the front of the building. This write did not see resident in the room and noticed the broken window. When this writer went outside this writer saw all the broken glass. A staff member which was sitting outside in the front porch of the building she heard the crash of the glass and saw the resident jump out the window and started running down the street and she and a CNA started to run after resident. This nurse returned to the building and called the police, description was provided, also called management. She was wearing a green blouse and camouflage pants and no shoes. CNA followed resident in the direction she was traveling, she then outran him, and he lost sight of her momentarily, however, other staff were dispatched to assist with the situation and search sorrowing area. Resident was traveling west and staff came down heading east. When the resident saw staff she ran into a coffee shop. Staff stayed monitoring resident through coffee shop window and also secured the exit doors. Barista stepped outside and informed the staff that the resident appeared to not want the staff inside the coffee shop. He went back inside and provided the resident with coffee and water as she sat at the coffee bar. EMS and police were activated. Up on arrival, 2 police officers and 2 EMS attendants restrained resident to the stretcher for transport to the hospital. Staff on sight noticed resident refused assessment by EMS. Resident out of facility. RN E wrote a statement, undated, and stated, I was contacted via telephone by ADON A regarding assistance with a resident that broke a window and left the facility. The nurse stated she was behind resident heading west towards downtown area on the street. Immediately headed towards that direction in my vehicle. Resident was spotted on the street heading to coffee shop. I followed resident in my vehicle and parked my care when I noticed resident going into the coffee shop. On arrival, [ADON A] was present. EMS and police department were on their way. We waited outside the coffee shop until they arrived. ADON A wrote a statement, undated, and stated, I received a call from the staffing ADON around 3:36 AM on 11/01/24 regarding a resident that broke the window, run away from the building but followed by staff. I immediately headed to the location of the resident and spotted her in abandon building in the street close to the facility. It was too dark around the area; I did not get close to her because I didn't want her to run. I kept in contact with co-workers around the area. When my co-worker came, she walked faster heading [NAME] of MLK as she was running from us until she reached the coffee shop. It appeared like she had seen me following her. We stayed outside of the coffee shop monitoring her through the window and keeping exit doors safe. All of the staff posted on the perimeter arrived at the coffee shop to assist. LVN B wrote a statement, dated 11/01/24, and stated, At approximately 2:30 AM resident was sleeping in bed. At approximately 3:20 AM; I heard a loud noise of glass breaking. This writer ran to resident room and CNA went to the front of the building. I did not see resident in the room and noticed the broken window. When I went outside I saw all the broken glass. A staff member which was sitting outside said resident jump out the window and started running down the street and CNA had ran after resident. CNA lost sight momentarily due to her already too far away. Both staff members stated the resident was wearing a green long sleeve shirt with camouflage pants, CNA said it looked like she possibly did not have shoes on. Police was called and given a description of resident also Management was called. 2 CNAs were driving around the area to see if they can spot resident. Also one C.N.A. and a nurse followed the resident on foot. Staff were told to no approach resident by them self's due to resident behavior to call for help if they see resident. I walked around the building to double check if resident had returned and also I and other staff members check all residents rooms in the facility. Nurse received a call from treatment nurse that she had spotted the resident and the resident ran into a coffee shop, and that all other staff arrived at the coffee shop to assist with resident. CNA F wrote a statement, undated, and stated, I was on my break, sitting outside the main entrance when I heard continuous banging by a window to the left, at 3:15 AM. I was on my way back into the building, when I heard a crash of glass and saw a female jump out of the window

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	due to aphasia secondary to cerebrovascular accident. Resident unable to communicate frustration/fear of persecution. IDT determined not reportable based on provider letter content. Elopement protocol/procedure re-education with staff initiated. During an interview on 11/06/24 at 9:29 AM, the MS stated a female resident [Resident #1] broke the window in her room. The MS stated he didn't know how the female resident broke the window in her room. The MS stated he couldn't recall the date when the female resident broke the window in her room, but believed the incident happened early in the morning before 7:00 AM or possibly 6:30 AM. The MS stated he got a call on 11/01/24 at 5:14 AM to come early to the facility to repair a window. The MS stated staff didn't tell him what happened and how the window broke other than the female resident broke the window. The MS stated no one was in room when he came to the facility. The MS stated on 11/01/24, he repaired the window, which was the 2nd time the female resident broke the window. The MS stated the first time the female resident broke her window in her room happened during the week of 11/01/24. The MS stated he and the other maintenance staff member repaired the window on 11/01/24 at 7:00 AM. An observation of the outside of Resident #1's room on 11/06/24 at 9:35 AM reflected there were still pieces of broken glass on the ground. Resident #1's window was repaired. Resident #1 wasn't in her room. During an interview on 11/06/24 at 9:42 AM, the MSA stated two weeks ago, a window broke. The MSA stated a couple days later, the same window broke a second time in the early morning. The MSA stated the first time was during the day the window broke. The MSA stated he cleaned up all the glass in the room. The MSA stated the second time was in the morning when the window broke and when he came to help repair it. The MSA stated when he got there, he was told the female resident [Resident #1] broke the window. The MSA stated he didn't know how the female resident broke her window and wasn't told how the female resident broke window. The MSA stated he didn't know why the female resident broke the window. The MSA stated he helped repair the window the same way as the first time. The MSA stated the first time the female resident broke her window, he had a replacement window and the second time the female resident broke the window, he had to have a company come out to replace the window. The MSA stated the window wasn't repaired any different than the first time he repaired the window. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/06/24 at 10:03 AM, the DON stated Resident #1 was in the hospital. The DON stated on 10/29/24, Resident #1 had a nervous breakdown and broke her window. The DON stated Resident #1's incident happened the week before Tuesday (10/29/24). The DON stated she was not sure if it was Tuesday, but believed it was 2 weeks ago on Thursday or Friday (10/24/24 or 10/25/24) when Resident #1's incident happened. The DON stated last Tuesday (10/29/24), Resident #1 broke the window the first time. The DON stated that around 6:00 am, Resident #1 had a delusion, saw that someone was trying to come through her window, and she broke the window. The DON stated she was out of the facility when Resident #1 broke the window. The DON stated she sent Resident #1 out to the hospital because she sustained a laceration and came back same day (10/29/24). The DON stated Resident #1 didn't go out the window the first time. The DON stated staff monitored Resident #1 every shift and psychiatric services visited Resident #1 after the incident. The DON stated Resident #1 was also put on medication (Ativan) after the incident. The DON stated she didn't know if staff documented monitoring Resident #1 every shift. The DON stated she tried to move Resident #1 to another room, but Resident #1 insisted to stay in the same room. The DON stated two days later (10/31/24), Thursday or Friday (10/31/24 or 11/01/24), Resident #1 broke the window again and left the facility. The DON stated the incident happened around 3:00 AM. The DON stated LVN H and CNA I saw Resident #1 and followed her to a coffee shop. The DON stated there were also staff in their cars who followed Resident #1. The DON stated she didn't know how long the LVN H and CNA I followed Resident #1 for. The DON stated Resident #1 sustained a laceration from the incident. The DON stated Resident #1 refused to let staff approach her during the incident. The DON stated Resident #1 had a nervous breakdown and was delusional. The DON stated she called EMS and they took Resident #1 to the hospital after the incident. The DON stated she was also not working the second time Resident #1 broke the window. The DON stated she didn't know why Resident #1 broke the window. The DON stated she answered her phone around 4:00 AM. The DON stated the ADM handled and managed Resident #1's incident. An attempt to contact Resident #1 was made on 11/06/24 at 10:!5 AM. A voicemail and call back number was left. Resident #1 didn't return the call before exit. An attempt to contact Resident #1's RP was made on 11/06/24 at 10:16 AM. A voicemail and call back number was left. Resident #1's RP didn't return the call before exit. An attempt to contact Resident #1's family was made on 11/06/24 at 10:17 AM. voicemail and call back number was left. Resident #1's family didn't return the call before exit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/06/24 at 10:25 AM, the ADM stated Resident #1 was a [AGE] year old female who had a stroke and left sided weakness. The ADM stated on 10/29/24 at 6:00 AM, Resident #1 broke the window twice. The ADM stated last week, Resident #1 broke her room window. The ADM stated Resident #1 told him that she saw a man, was afraid, and broke her window. The ADM stated Resident #1 didn't leave after she broke the window, staff responded to the incident, and staff repaired window. The ADM stated the staff did medication changes and sent a psychiatric referral for Resident #1. The ADM stated staff didn't repair Resident #1's window any differently after her incident. The ADM stated Resident #1 used an object to break the window. The ADM didn't describe what the object was that Resident #1 used to break the window. The ADM stated staff heard glass breaking and LVN C was working during the time. The ADM stated on 11/01/24 in the early morning, Resident #1 broke the window. The ADM stated ADON J, who was notified by LVN B, who was notified by CNA I that CNA I heard glass break and observed Resident #1 climb out the window. The ADM stated a nurse, who was outside the facility, also observed Resident #1 climb out the window. The ADM stated Resident #1 outran staff and disappeared passed the funeral home. The ADM stated staff conducted a call tree and were unable to locate Resident #1 until an hour later. The ADM stated Resident #1 was found on the street in her panties and a shirt. The ADM stated Resident #1's pants were found on a fence. The ADM stated RN E observed Resident #1 running into traffic and into a 24 hour coffee shop. The ADM stated staff held Resident #1 at the coffee shop. The ADM stated he notified the police department and EMS. The ADM stated Resident #1 vigorously fought the police department and EMS. The ADM stated the hospital notified staff that Resident #1 had schizophrenia and bipolar disorder, which the facility didn't know. The ADM stated the police department was familiar with Resident #1. The ADM stated Resident #1 used paper towels and assumed she broke the window with her hands. The ADM stated Resident #1 cut her arm along a fence that she hopped and hid in someone's backyard. The ADM stated staff only observed Resident #1 observed fence cut on her arm and no cuts anywhere else. The ADM stated Resident #1 told him that she broke the window because she was afraid. The ADM stated ST and IDT interviewed Resident #1 and all Resident #1 wrote was scary on a piece of paper. The ADM stated he didn't know when ST and IDT interviewed Resident #1. The ADM stated he didn't get to interview Resident #1. The ADM stated he didn't know Resident #1 had a history of schizophrenia and was not on a normal medication regimen for the diagnosis. The ADM stated he didn't report the incident to the SA because it didn't meet the reporting criteria and because Resident #1 was seen leaving by staff, knew where Resident #1 went, and never stopped looking for Resident #1. The ADM stated Resident #1 didn't elope, had a psychotic break, had a case of psychosis, and that her incident didn't meet definition of elopement. The ADM stated had he felt it was a reportable incident, he would've called it in to SA. The ADM stated the fact staff saw Resident #1 leave, reviewed Resident #1's incident, did AD-HOC (a meeting scheduled outside normal schedule) QAPI, looked at multiple areas, and did an investigation and timeline, he believed Resident #1's incident wasn't reportable and staff responded appropriately. The ADM stated to report elopement, it would be within 24 hours or immediately and if the incident involved serious injury. The ADM stated according to the latest provider letter, the facility had 24 hours to report the incident to the SA. The ADM stated residents couldn't be impacted if their incidents were not reported to SA. The ADM stated he didn't consider Resident #1 to have been a missing resident during the incident. An attempt to contact LVN C was made on 11/06/24 at 11:06 AM. A voicemail and call back number was left. LVN C didn't return the call before exit. An attempt to contact RN K, who worked on Resident #1's hall on 10/31/24, was made on 11/06/24 at 11:29 AM. A voicemail and call back number was left. RN K didn't return the call before exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455599	A. Building B. Wing	11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Park Rehabilitation and Skilled Nursing C	2806 Real St Austin, TX 78722

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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	During an interview on 11/06/24 at 11:31 AM, NA L stated he observed Resident #1 was restless on 10/31/24 from 2:00 PM through 10:00 PM. NA L stated he believed Resident #1 was restless because she kept coming in and out of her room. NA L stated he wasn't sure, but he believed LVN C was working with him on 10/31/24. NA L stated he didn't work on 11/01/24. NA L stated he came back to work at the facility on 11/02/24, but Resident #1 wasn't at the facility. NA L stated he signed an in-service betw [TRUNCATED]