STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455715	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Rehabilitation and Nursing Center	120 State Loop 92 LA Grange, TX 78945

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 observations, interviews, and record reviews, the facility failed to provide adequate supervision for 1 of 5 residents reviewed for accidents and supervision. (Resident #1) The facility failed to ensure Resident #1 received adequate supervision to prevent elopement. On 04/08/2025, Resident #1 eloped from the facility through a side door and was later found by a neighbor in a grassy area approximately 219 feet away from the facility. This failure placed the resident at risk for serious harm.The non-compliance was identified as past non-compliance. The immediate jeopardy began on 04/08/2025 and ended on 04/14/2025. The facility had corrected the noncompliance prior to the start of the survey. The facility had implemented corrective actions and returned to compliance before the investigation began.This failure had the potential to affect other residents and could result in residents not receiving appropriate supervision, placing them at risk for serious injury, harm, or death. Upon entry to the facility, on 07/01/2025 an observation was conducted on all exit doors. The observations revealed that all doors were locked and equipped with functioning alarms. Additionally, it was observed that the side door in the activity room provided access to the area where Resident #1 had eloped. Resident #1 walked/used her wheelchair to ambulate to a grassy area across the way from the facility. Resident #1 is believed to have crossed a side driveway to the facility and then a street entering a neighborhood.Record Review of Resident #1's electronic facility face sheet dated 07/01/2025, revealed she was a [AGE] year-old female admitted to the facility originally on 08/08/2022 with the most recent admission on [DATE]. Her diagnoses included Cognitive communication Deficit(thinking and speaking difficulty), Repeated Falls, Unspecified Dementia with agitation(memory decline with acting out), Hypertension(high blood pressure), and Hypothyroidism unspecified(underactive thyroid).Record Review of Resident #1's MDS Assessment, dated 04/14/2025, reflected Resident #1 was unable to complete brief interview for mental status. Resident #1 had poor short-term memory recall. Her decision-making ability was severely impaired. Record review of Resident #1's care plan with a closed date of 04/25/2025 due to discharge indicated: Resident had an actual elopement: Fall occurred on 4/8/2025 during elopement attempt interventions included: Monitor 1:1 until resident is stable, Psychiatric NP will complete a medication review. Make recommendations as needed, and UA and Labs collected .Record review of Resident #1's wandering risk assessment dated [DATE] indicated a wander score of 05 which was a low wandering risk category. Record review of Resident #1's wandering risk assessment dated [DATE] indicated not a wandering risk category.Record review of Resident #1's wandering risk assessment dated [DATE] indicated Resident was a wandering risk. The assessment indicated an intervention of : Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Record review of hospital discharge records dated 04/9/2025 indicated Resident #1 fell out of her wheelchair. There was no injury to head or neck. There were no fractures noted anywhere. They put an Ace wrap on her right wrist for comfort and support.Interview with ex-maintenance director, 07/01/2025 revealed he was terminated when the door to the exterior in the activities room was left unlocked and Resident #1 was able to elope from the facility. He stated the door was unlocked and the alarm did not sound from what he heard from staff. He stated he worked earlier that day and was not at the facility when resident eloped. He stated he locked the door in the Activity room that leads to the courtyard and left the activity room from the door that led to the hallway. He stated another staff member must have left the door unlocked. He stated the resident was found at night in a grassy area next to the facility by a neighbor who then called EMS and the administrator of the facility. Ex-maintenance director stated the facility blamed him for this incident, but he was not working nor in charge of the resident.Interview with AD, 07/01/2025 revealed she was not working when Resident #1 eloped from the facility. AD just returned to work 2 days ago. AD stated the activity room door stayed locked when there was no activity. She stated the door leading to the courtyard, locked automatically from the outside. AD could not recall when the alar was installed on the activity room door.Interview with MA, 07/01/2025, revealed she was working the night Resident #1 eloped from the facility. She reported she administered Resident #1's nighttime medications at 8:30 PM. She stated she later heard Resident #1 had been found across the facility driveway in a grassy area outside the nearby neighborhood. She stated Resident #1 typically only walked when agitated so staff were surprised by the location where Resident #1 was found with her wheelchair beside her.Interview with LVN , 07/01/2025 revealed she last saw around 9:00 PM on hall 200 (which is not Resident #1's hallway). She stated Resident #1 was sundowning and disturbing two residents on the