STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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** 45070 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for elopement. Resident #1 walked out of the facility unattended on 03/15/2024 at about 9:00PM until the police found him at about 10:00 PM from a place approximately 1.5 miles away from the facility. EMS organized by the police to take him to the hospital and at the hospital it was confirmed that resident had hairline fracture above the left eye and cheek with lacerations on left eye lid, left wrist, and lower and upper lips, and abrasions on hands. The facility staff was not aware the resident was missing until the family called the facility. This was determined to be an Immediate Jeopardy (IJ) on 03/25/24 at 4:55 PM. The Administrator and DON were notified. The Administrator was provided the Immediate Jeopardy Template on 03/25/24 at 6:00 PM. While the IJ was removed on 03/27/24, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could affect residents by placing them at risk of physical harm, pain and mental anguish, or emotional distress. Findings Included: Record review of Resident #1's face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] and discharged on [DATE]. His diagnoses included Parkinsonism (brain conditions that cause slowed movements, stiffness, and tremors), Prostatic Hyperplasia (enlarged prostate gland), Hypothyroidism, Hearing Loss-Left ear, and Abnormal Involuntary Movements. Record review of Resident #1's admission MDS dated [DATE] revealed a BIMS Score of 13 indicating Resident #1 was cognitively intact. Record review of Resident #1's Baseline Care Plan dated 03/10/24 reflected Resident #1 had no history of falls and no elopement risk. (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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NAME OF PROVIDER OR SUPPLIER: Austin Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 11406 Rustic Rock Drive Austin, TX 78750	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Elopement Risk Evaluation dated 03/16/24 reflected a score of 14.00 indicating Resident #1 was at imminent risk for elopement. No Elopement Risk Evaluation completed prior to the elopement. Record review of the care plan completed after the incident, dated 03/16/24 reflected , Resident #1 was at risk for elopement related to Elopement Evaluation Risk Score. No care plan was completed prior to the elopement incident. Record review of the Weekly Skin Check dated 03/16/24 reflected Resident #1 had lacerations on left eye lid, left wrist and lower and upper lips. Record review of Trauma Informed assessment dated [DATE] reflected Resident #1 felt scared, helpless, or horrified related to the sudden event of elopement with fall. Record review of facility's incident report to HHSC dated 03/18/24 reflected, on 3/15/2024 the ADM was notified by MDS C that on 03/15/24, Resident #1 was being transported to the hospital for further evaluation and treatment related to fall with injury after found him outside the facility at a place half a mile away. The facility came to know about this incident when the FM of Resident #1 notified the facility over the phone at 10:20PM, that the resident was off the property. She also informed the facility that resident was on his way to the hospital. At the hospital it was revealed that Resident #1 had a hairline fracture above the left eye and the left cheek. Resident also had abrasions on his hands. Record review of Nurses Progress Notes for Resident #1 by RN B on 03/16/24 at 6:41 AM, reflected Resident arrived from [Hospital] ER. Resident arrived with acute head injury orbital fracture, lip laceration Zygomatic arch fracture. Wander guard was placed on resident right lower leg. Notified doctor of return. Family is aware of return. Resident is comfortable at this time. During an interview over the phone on 03/25/24 at 10:30 AM, Resident #1's FM stated she was out of the state when the incident of the elopement occurred. She stated at about 10:00PM the police called and talked to her over the phone and said that they went and picked Resident #1 up from a place approx. 1.5 miles away from the facility. She said the police reported that they responded to a 911 call from a community member who found Resident #1 with injuries braced on his parked car. She said the police organized EMS and transported him to the nearby hospital for further assessment and treatment. The FM stated the facility was unaware of Resident #1's disappearance from the facility until she called and informed the FR at the facility at about 10:20 PM. FM stated, initially when she asked about Resident #1, the FR stated Resident #1 resides at the 2nd floor and she would transfer FM's call to the 2nd floor nursing station so that FM could request the staff to talk to him. (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 over the phone on 03/25/24 at 11:00 AM, FR stated she worked as the receptionist at the facility from 6:00 PM to 10:30 PM, Monday to Friday. She said, on 03/15/24 at about 10:20 PM she received a phone call from Resident #1's FM asking if Resident #1 was there at the facility. FR said, she replied to FM that Resident #1 was living on the 2nd floor, and she would transfer the call to the nursing station at the 2nd floor so that the FM could talk to the staff there. FR said, FM then reported to FR that she was checking if staff was aware of what was going on and then reported that the police had picked up Resident #1 from a place about 1.5 miles away from the facility at about 10:00 PM and admitted to a hospital nearby due to the injuries he had. FR stated she or anyone at the facility was aware until then that Resident #1 was absconded from the facility. FR said at about 10:00 PM LVN A at the 2nd floor enquired her if she saw Resident #1 at the 1st floor as they could not find him at the 2nd floor. FR stated they were under the impression that Resident #1 was wandering around within the facility until they heard about his elopement from the facility from the FM. FR said, on 03/13/24 Resident #1 was persistently requesting to her to let him leave the facility and made unsuccessful efforts to open the coded front door at two different occasions. FR stated this behavior from him was evident since his admission on 03/08/24 and LVN A from 2nd floor requested her to have a [NAME] on Resident #1. She stated she also had informed LVN A about his attempts for unauthorized exit. FR stated she had a watch on him whenever he was on 1st floor and ensured that he did not exit through the front door on 03/15/24 as she was the only one who allowed the visitors to come and go from the facility. She stated the front door was secured with code numbers and only the staff members knew the code number. FR said she believed Resident #1 might have exited through the emergency fire exit door situated at the back of the facility. FR added, though the back door secured by code numbers, the lock can be override if the handle of the door holds down for some time. The door will be opened with an alarm though the alarm would not be heard at the reception area. During an interview on 03/25/24 at 10:00 AM, MDS C stated she worked at the facility in the morning shift until 5PM. She said, on 03/15/24 at about 10:30PM she received a phone call at home from FR stating Resident#1 eloped from the facility and had a fall. FR reported to her that the police found him about 1.5 miles away from the facility with lacerations on his body and admitted him to a nearby hospital for treatment. MDS C stated, as per her understanding the staff at 2nd floor did not find him there at about 9.45PM and then they informed FR to have a watch on him if he appears at the front door. She stated it appeared the staff came to know his exit out of the facility only after the FM passed on that information During a telephone interview on 03/25/24 at 10:30, LVN A stated she worked in the afternoon shift on 03/15/24 with the responsibility of the hall where Resident #1 resided. She said on 03/15/24 Resident #1 accepted his night medication at 9:00PM in his room. At about 9:45PM one of the CNAs noticed that Resident #1 was not in his room and his name tag at the door also was missing. LVN A stated she immediately informed FR to check if he was there at the reception area and by that time the information about his elopement was received from the FM of Resident #1. LVN A stated according to her Resident #1 was not an elopement risk as he mostly stayed in his room. When this investigator asked her about an incident of his two unsuccessful attempts to get out of the facility on 03/13/24 in the evening, reported by FR, LVN A stated those were the only attempts she was aware of. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 03/25/24 at 3:00PM, RN B stated she was the night nurse at the facility and was not aware of what was going on with Resident #1 until 10:00 PM as she was not in charge of his hall. RN B stated the staff at the facility came to know through the FM about Resident #1's disappearance and subsequent incident of finding him outside the facility. RN B stated Resident #1 arrived back at the facility on 03/16/24 at about 6:00 AM from the hospital. She said she had a nurse-to-nurse communication from the nurse at the hospital. RN B stated, the nurse from the hospital reported Resident #1 had an acute head injury, orbital fracture, lip laceration and Zygomatic Arch (the most lateral projection of the midface) fracture. She stated she had recorded this in the progress note in the electronic medical record. During an interview on 03/26/24 at 10:00 AM, LVN C stated she worked at the facility for more than a year and worked the morning shift. She said she did not work on the hall where Resident #1 resided. LVN C stated the nursing stations at the 2nd floor were equipped with alarms and any attempt to open the doors downstairs trigger the alarm. She added, staff immediately go down to ensure no elopement attempt was made by any residents. LVN C stated she did not know what really happened on that day as the incident occurred on the night shift. In an interview and observation walk through with the ADM on 03/25/24 at 3:00 PM, she stated Resident #1 must have exited through the emergency fire exit door at the back, adjacent to the kitchen. ADM stated she believed it was not an elopement since the facility was not a locked facility. She added, stopping anyone from leaving the facility, when they wanted to, was a violation of resident rights. The ADM stated Resident #1 had a BIMS score of 13, indicated intact cognition to make independent decisions. The ADM stated there was residents at the facility who regularly go Out-On-Pass to the community and return within the stipulated time (72 hours). When this investigator asked if Resident #1 left the facility as per the policies and procedures for Out-On-Pass, she stated, he was not. The ADM also stated, Resident #1 neither signed any AMA documents nor declined to sign one and exited without the knowledge of any staff members. Observation of the emergency exit door revealed there was an instruction posted on the door explaining how to override the passcode in case of any emergency however an alarm went off when opened without the passcode. The ADM said since the door was away from the reception it was difficult to hear the alarm from the reception area. Observation of the front door revealed, it was secured by number code and the entrance and exit was controlled by the receptionist. There were no other exit doors at the facility. During an interview on 03/26/24 at 12:50 PM, the DON stated he started working at the facility about a week ago, after the elopement incident of Resident #1 occurred. He stated he was well informed about the incident. The DON defined an elopement as, a resident leaving the facility without any notice or knowledge of the facility. The DON stated it appeared there was some shortfall in the security measures at the backdoor as it was believed Resident # 1 accessed the back door for his exit on 03/15/24. The DON stated it seemed the elopement risk evaluation and nursing judgement also was not accurate as there was no management plan, like usage of a wander band in place. The DON stated, when an alarm would be heard at nursing stations, the staff was supposed to go down to the 1st floor and make sure the alarm went off not because of any resident's attempt for an unauthorized exit. During an interview on 03/26/24 at 1:10 PM, MDS C stated she did not know how Resident #1 got out of the facility. She stated she was the MDS nurse and was helping the administrator within her scope of practice as an LVN, in the absence of a DON at that time. She stated the act of Resident #1 was elopement if he exited the facility without the knowledge of the staff and without completing Out-On-Pass paperwork or without signing an AMA form. (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 undated facility policy Elopement Risk Reduction Approaches reflected. Planning: As necessary, provide new residents (to the facility, wing, unit ,etc.) with additional staff assistance until they are comfortable in their new environment . Ensure that residents are able to move freely, are monitored and remain safe . .Training: Facility staff needs to know: . The resident's propensity to wander and the triggering conditions The consequences of unsafe wandering, the protocols to follow to minimize successful exiting and the procedures to follow when resident is lost . Promote identification of residents who are at risk of elopement. Ensure that photographs of residents who wander are maintained in an accessible but secure location and that receptionist, activities and clinical staff and others in appropriate positions to help are able to recognize at-risk residents and to assist in redirecting them .Environment: Ensure that staff alert and elopement alarm/warning systems are the least intrusive and burdensome possible After conferring with fire and other appropriate officials, minimize the risk of elopement. An Immediate Jeopardy was identified on 03/25/24 at 4:55 PM. The IJ Template was provided to the facility ADM on 03/25/24 at 6:00 PM. The following Plan of Removal submitted by the facility was accepted on 03/26/24 at 7:01 PM and indicated the following: Plan of Removal Immediate Jeopardy On 03/25/2024 an abbreviated survey was initiated at the facility. On 03/25/2024 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: F689 - The facility failed to provide an environment free of accident hazards to minimize elopement risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Resident #1 discharged from facility as planned at the end of respite stay on 3/17/2024. Start Date: 3/17/2024. Completion Date: 3/17/2024 Action: All residents re-evaluated for risk of elopement via assessment on 3/25/2024. No additional residents were identified based on evaluation. Elopement Binder up to date and remains at reception desk. DON ensured all residents who are imminent risk for elopement are donning a wander guard for safety. Start Date: 3/25/2024. Completion Date: 3/25/2024 Responsible: DON or Designee Action: Medical Director notified of IJ on 3/25/2024 Start Date: 3/25/2024. Completion Date: 3/25/2024 Responsible: Administrator Action: Physician orders related to residents on wander guard placement reviewed and updated for all residents Start Date: 3/25/2024. Completion Date: 3/26/2024 Responsible: Medical Director or Designee Action: In-services completed with all staff (facility does not use agency, all staff to include PRN staff) related to Elopement (Code Pink/Elopement Protocol, Midnight Census/Headcount/Walking Rounds, Resident Rights, Out on Pass Policy, AMA policy, Monitoring and Redirecting any wandering residents, Reporting Incidents to Admin and DON In-services Initiated and Completed). As new employees are hired they will be in-serviced on all protocols in hire process. Start Date: 3/25/2024 Completion Date: 3/26/2024 Responsible Human Resources or Administrator (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: In-service completed with all staff (facility does not use agency, all staff to include PRN staff) that if resident has more than one request to leave that elopement/wandering risk assessment completed and wander guard placed if applicable as intervention for safety. Elopement risk reduction approaches policy reviewed with all staff. As new employees are hired they will be in-serviced on protocol in hire process. Start Date: 3/26/2024 Completion Date: 3/26/2024 Responsible Human Resources or Administrator Action: QAPI meeting held related to IJ. Administrator, HR, DOR, Activities Director, DON, MDS, BOM, BD, Maintenance, DCT, and Medical Director (via phone) present. Start Date: 3/26/2024. Completion Date: 3/26/2024 Responsible Administrator Action: HR and Administrator in-serviced by Regional Clinical Specialist on all in-services, to include Code Pink/Elopement Protocol, Midnight Census/Headcount/Walking Rounds, Resident Rights, Out on Pass Policy, AMA policy, Monitoring and Redirecting any wandering residents, Reporting Incidents to Admin and DON, and Elopement risk reduction. Start Date: 3/25/2024. Completion Date: 3/25/2024 Responsible: Regional Clinical Specialist The surveyor confirmed the facility implemented their plan of removal sufficiently from 03/25/24 through 03/27/24 to remove the IJ by: 1. Record review of Resident #1's face sheet confirmed Resident #1 discharged from facility as planned at the end of respite stay on 3/17/2024. 2. Record review of an Inservice to all nursing and CNA staff was completed on 03/27/24 by ADM and HR related to Elopement (Code Pink/Elopement Protocol, Midnight Census/Headcount/Walking Rounds, Resident Rights, Out on Pass Policy, AMA policy, Monitoring and Redirecting any wandering residents, Reporting Incidents to Admin and DON In-services Initiated and Completed). HR and Administrator were in-serviced on the above topics by Regional Clinical Specialist 3. Record review of the medical records of all the resident at the facility revealed all residents re-evaluated for risk of elopement via assessment on 3/25/2024 and ensured all residents who are an imminent or moderate risk for elopement had wander guards for safety. (continued on next page)

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Record review of the Elopement Binder revealed it was up to date and remains at reception desk. Copies of them were available at Nursing stations. 5. Record review on 03/27/24 of the medical records of all residents revealed physician orders related to residents on wander guard placement reviewed and no additional residents added to the existing residents with elopement risk. 6. Record review of the minutes of the QAPI meeting that was conducted for discussing elopement prevention on 03/26/24 revealed that the medical Director attended via Phone and Administrator, HR, DOR, Activities Director, DON, MDS, BOM, BD, Maintenance, DCT were physically attended the meeting. Interviews conducted with RN C on 03/27/24 at 10:15 AM; LVN A on 03/26/24 at 11:00 AM; LVN C on 03/26/24 at 10:00AM. CNA A on 03/27/24 at 11:15AM, revealed nurses was in serviced on 03/27/24. Nurses verbalized attending to call lights, rounding every 2 hours, checking any alarm doors to ensure that no resident had eloped, taking mid night census, do head count to make sure no resident missing. ADM was notified that while the IJ was removed on 03/27/24 at 00:00, the facility remained out of compliance at a scope of isolated at a level of no actual harm due to the facility's need to evaluate the effectiveness of the corrective systems.