

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455941	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2025
NAME OF PROVIDER OR SUPPLIER Enchanted Rock Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 210 West Windcrest St Fredericksburg, TX 78624	
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** 48366 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made for 2 (Resident #1 and #2) of 26 residents reviewed for reporting of alleged violations, in that: The facility failed to report to the state agency: 1. an elopement incident regarding Resident #1, after he had taken a car that did not belong to him from the nursing home parking lot and drove to a town over 60 miles away . 2. an incident involving a missing resident (Resident #2). This failure could place facility residents at risk of harm due to delays in reporting allegations of abuse and neglect. Findings included: 1. Record review of Resident #1's Admission record, dated 01/15/25, reflected a [AGE] year-old male with admitted [DATE] and discharge date [DATE]. It reflected Resident #1 had diagnoses to include alcohol abuse with intoxication delirium (a mental state in which you are confused, disoriented, and not able to think or remember clearly) and alcohol dependence with alcohol-induced persisting amnesic disorder (a disturbance in memory). Record review of Resident #1's BIMS assessment, dated 09/04/24, reflected a score of 10 out of 15, indicating moderate impairment. Record review of Resident #1's Baseline Care Plan assessment, dated 08/30/24 and created by ADON B, reflected no answers for sections 3. Health Conditions . B. Level of Consciousness/Cognition . H. Safety Risks . 9. Is the resident an elopement risk?, mental health needs, and behavioral concerns. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455941	Facility ID: 455941 If continuation sheet Page 1 of 20

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Elopement Risk Assessment, dated 08/31/24, reflected Resident #1 was Moderately impaired-decisions poor; cues/supervision required with One or more times [previous attempts to leave residence/facility] in the last week. It further revealed Resident #1 did not recognize stop lights and signs, did not know precautions when crossing streets, did not know location of current residence, and did not recognize physical needs. The assessment further revealed he was at high risk for elopement and Wanderguard (technology where the facility will be alerted if a resident wearing a wanderguard bracelet gets close to an exit door) appropriate at this time-initiate wanderguard interventions. Record review of Resident #1's September 2024 MAR, dated 01/15/25, reflected: VISUAL CHECK EVERY 2 HOURS . for elopement risk with a start date of 08/31/2024. WANDER GUARD CHECK PLACEMENT EVERY SHIFT . with a start date of 09/04/24 and D/C Date of 09/10/24 . During an interview on 01/16/25 at 01:40PM, Confidential Staff N revealed they heard no one was going to report when Resident #1 eloped and was found in a different city about an hour away. They further revealed ADM G picked Resident #1 up and brought him back to the facility but was not aware of anything else. They revealed they were told not to report this incident to HHSC because the facility was going to handle this incident a different way. During an interview on 01/16/25 at 02:37PM, ADM G revealed Resident #1 had alcohol induced dementia. ADM G revealed Resident #1 told him he looked out the window one night and thought he saw his wife's car and it was time to go home. ADM G revealed he remembered the facility staff called him, the police were involved, they tracked his phone, and the authorities had pulled him over in another town about an hour away. ADM G revealed he drove to the town to pick Resident #1 up from the police station. He revealed Resident #1 did not know where he was going. He revealed he had a conversation with the facility's ownership immediately about this incident. ADM G further revealed he thought this incident was reportable. ADM G revealed the COO gave them direction to not report this incident to HHSC. ADM G revealed Resident #1 did not have a wander guard bracelet. He revealed the front doors going outside did not lock overnight. He revealed he remembered knowing this was an issue, figuring out how to prevent residents from leaving the facility overnight. ADM G after he picked up Resident #1, he filled out a self-report form, in-serviced some staff about ANE and elopement and was still working on this. He revealed he started the paperwork as soon as he came into the building because he knew he was on the clock to complete it in order to report it to HHSC. 2. Record review of Resident #2's Admission record, dated 01/15/25, reflected an [AGE] year-old male with an admitted [DATE] and discharge date [DATE]. It reflected Resident #2 had diagnoses to include dehydration, altered mental status, muscle weakness, abnormalities of gait or mobility, lack of coordination, dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), and depression. Record review of Resident #2's Care Plan, close date 09/09/24, reflected focus The resident is an elopement risk/wanderer r/t impaired safety awareness, initiated 08/15/24 with interventions to include WANDER ALERT bracelet check placement and functioning q shift. Record review of Resident #2's August 2024 MAR, dated 01/15/25, reflected: (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	WANDER GUARD CHECK FOR FUNCTION EVERYDAY. with a start date of 08/14/24 and D/C Date 09/03/24, filled out appropriately for day and night shifts. VISUAL CHECK EVERY 2 HOURS with a start date of 08/14/24 and D/C Date 09/03/24, filled out appropriately. Record review of Resident #2's Elopement Risk Assessment, dated 08/14/24, reflected Resident #2 was Moderately impaired-decisions poor; cues/supervision required with One or more times [previous attempts to leave residence/facility] in the last week. It further revealed Resident #2 did not recognize stop lights and signs, did not know precautions when crossing streets, did not know location of current residence, and did not recognize physical needs. The assessment further revealed he was at high risk for elopement and Wanderguard appropriate at this time-initiate wanderguard interventions. Record review of Alert Note, authored by AD, dated 08/22/24 at 12:06PM, reflected, AD finished exercise group in main dining room and on the way back to AD's office, alarm in activities room was going off. AD looked out the outside door to make sure no one had gone out. Upon looking down the sidewalk resident was spotted going down looking (sic) at cars. She thought her son was out there. AD approached and redirected resident back to building and inside. AD and resident went to find the charge nurse to let her know about the adventure. [DON] was at the nurse's station as well, so she is (sic) aware of the incident. Record review of Resident #2's progress notes and assessments reflected no skin assessments were done after Resident #2 was found outside of the facility on 08/22/24 around 12:06PM During an interview on 01/15/25 at 12:15 PM, LVN E revealed if a resident left the building and there were no eyes on the resident, she would complete a skin assessment on resident. After reading the alert note on 08/22/24 at 12:06PM, LVN E revealed she would have done a skin assessment on Resident #2 because Resident #2 exited the building and it appeared there was some time where a staff member wasn't with Resident #2 . During an interview on 01/16/25 at 08:13 AM, the DON revealed Resident #2 was found on the facility sidewalk by the AD. She revealed Resident #2 was still on property and this incident was not reported because Resident #2 was on the premises . During an interview on 01/16/25 at 01:05PM, the AD revealed she had heard the door next to her office sound, so she went to check to see if a resident had left the building. She revealed Resident #2 was observed walking on the sidewalk between the nursing home parking lot (on her left) and the facility building/yard (on her right). The AD revealed Resident #2 was able to walk past 3 trees on the right side of her before she laid eyes on Resident #2. The AD revealed she was able to go outside and redirect Resident #2 to come back into the facility. The AD revealed she was trained on elopement this morning and had already been trained prior to this morning. Record Review of TULIP from March 2024 to present, database that contains facility self-reports of reportable incidents that occur, did not reflect any self-reports about any elopements. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of facility's policy Wandering and Elopements, revised March 2019, reflected The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . 4. When the resident returns to the facility, the director of nursing services or charge nurse shall: a. examine the resident for injuries; b. contact the attending physician and report findings and conditions of the resident . e. complete and file an incident report . Record review of facility's policy Abuse, Neglect, and Exploitation, implemented 07/22, reflected, 'Neglect' means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. and 2. The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. and VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes . Record Review of Texas Health and Human Services's Long-Term Care Regulation Provider Letter, issued 08/29/24, reflected the following: 2.1 Incidents that a NF Must Report to HHSC . Neglect, A missing resident . CMS defines neglect as, the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Example of a missing resident: A resident is not in his room when staff wake residents up in the morning . Staff search the facility and cannot find the resident.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that include measurable objectives and time frames to meet residents' mental, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and to ensure that the comprehensive care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including the right to refuse treatment for 16 of 26 residents (Residents #11-#26) reviewed for care plans, in that. Resident #11 through Resident #26 were at high risk for elopement after completing their respective Elopement Risk Assessment and their care plans were not updated to reflect this finding per facility policy and interviews. This failure could affect residents who have care areas not addressed by the care plans by not having their needs met and putting them at risk of not receiving appropriate care. The findings included : Record review of Resident #11's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 13, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #11's Care Plan, last updated 01/14/25, reflected diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (partial weakness on one side of the body), dementia (group of symptoms affecting memory, thinking, and social abilities), cognitive communication deficit. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #12's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 20, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #12's Care Plan, last updated 01/14/25, reflected a diagnosis that included dementia, hypertension (high blood pressure), anxiety. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #13's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 15, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #13's Care Plan, last updated 01/06/25, reflected a diagnosis that included Alzheimer's (a brain disorder caused by damage to nerve cells in the brain), type 2 diabetes mellitus, congestive heart failure (long-term condition in which the heart can't pump blood well enough to meet the body's needs), hypertension. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #14's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 12, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #14's Care Plan, last updated 01/03/25, reflected a diagnosis that included hypertension, altered mental status and macular degeneration (vision impairment). The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #15's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 10, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #15's Care Plan, last updated 12/11/24, reflected a diagnosis that included dementia and dysphasia (language disorder that affects speech production and comprehension). The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #16's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 16, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #16's Care Plan, last updated 01/06/25, reflected a diagnosis that included paranoid schizophrenia (reoccurring delusions or hallucinations that are grandiose), anxiety, and lack of coordination. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #17's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 18, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #17's Care Plan, last updated 01/06/25, reflected a diagnosis that included hypertension, dementia, epilepsy (brain condition that causes recurring seizures due to abnormal brain activity), dysphasia, heart failure, and abnormalities of gait and mobility. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #26's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 25, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #26's Care Plan, last updated 01/14/25, reflected a diagnosis that included hypertension, heart failure, and muscle weakness. The Care Plan further reflected focus area indicating the resident was at risk of elopement initiated 01/14/25. Record review of Resident #18's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 19, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #18's Care Plan, last updated 01/06/25, reflected a diagnosis that included hypertension, chronic obstructive pulmonary disease (lung and airway diseases that restrict your breathing), dementia, and heart failure. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #19's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 12, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #19's Care Plan, last updated 1/6/25, reflected a diagnosis that included dementia, cognitive communication deficit, hypertension, and lack of coordination. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #20's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 11, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #20's Care Plan, last updated 01/06/25, reflected a diagnosis that included Alzheimer's Disease, hypertension, and kidney disease. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #21's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 11, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #21's Care Plan, last updated 01/06/25, reflected a diagnosis that included hypertension, muscle weakness, abnormal gait and mobility, and chronic kidney disease. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #22's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an initial admitted [DATE]. The document further reflected an elopement risk score of 14, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #22's Care Plan, last updated 01/06/25, reflected a diagnosis that included other specified mental disorders due to known psychological condition, kidney failure, anxiety disorder, and dysphasia. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #23's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 13, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #23's Care Plan, last updated 01/09/25, reflected a diagnosis that included unspecified dementia with mood disturbance, hemiplegia and hemiparesis following cerebral infarction affecting left side. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #24's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 14, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #24's Care Plan, last updated 01/17/25, reflected a diagnosis that included epilepsy, altered mental status, muscle weakness and abnormalities of gait. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Record review of Resident #25's Elopement Risk Assessment, dated 01/16/25, reflected resident was [AGE] years old with an admitted [DATE]. The document further reflected an elopement risk score of 10, indicating high risk for elopement. The assessment reflected, IDT has determined Wanderguard not indicated at this time - resident is not actively exit seeking. Record Review of Resident #25's Care Plan, last updated 01/13/25, reflected a diagnosis that included acute respiratory failure with hypoxia (low levels of oxygen in your body tissues) and anxiety. The Care Plan further reflected no focus area indicating the resident was at risk of elopement. Observation on 01/17/25 from 03:00 PM to 03:15 PM reflected that the 16 residents at risk for elopement were present in the facility. During an interview on 01/17/25 at 02:37 PM, MDS nurse AJ revealed she had no explanation why the residents with high-risk elopement scores had no goals or interventions reflected in their care plans. MDS nurse AJ revealed care plan goals and interventions were decided at admission, a change of condition, and quarterly assessments. MDS nurse AJ revealed she was responsible for the comprehensive care plan and any updates. MDS nurse AJ further revealed once the care plan was developed the Kardex should reflect interventions involving elopement and other treatment recommendations . (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/17/25 at 03:27 PM, the DON revealed assessments and change of conditions drove the care plan development and updates; and the care plans were updated quarterly. The DON revealed the care plan served as a communication tool for staff to know goals and interventions for each resident. The DON stated MDS nurse AJ was responsible for updating the care plans from input from the interdisciplinary team. The DON revealed she could not explain whys the care plans were not updated for 15 of 16 residents identified as high elopement risk. The DON revealed the care plans should have been updated because the care plan drove the care given by the staff . Record Review of facility's policy Wandering and Elopements, revised March 2019, reflected The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Record review of facility's Comprehensive Care Plans, dated 07/2022, read: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 48366 Based on interviews, observations, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 3 of 26 residents (Resident #1, #2, and #3) reviewed for accidents and hazards supervision, in that: 1. Resident #1 was found in in another town about an hour's drive from the facility. 2. Resident #2 was spotted going down looking (sic) at cars outside of the facility and had not been supervised the whole time she was outside of the facility. There were no assessments (to include skin assessments) done for Resident #2. 3. Resident #3 eloped and was found walking down the street. Resident #3 had a wander guard but nursing staff did not hear any door alarm with this exit. An IJ was identified on 01/16/25 at 04:45 PM, The IJ template was provided to the facility on [DATE] at 05:45 PM. While the IJ was removed on 01/19/25 at 01:06 PM, the facility remained out of compliance at a scope of a pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on supervision and elopement. This deficient practice could result in a risk to the residents' health and safety and placed the residents at risk of heat or cold exposure, dehydration and/or other medical complications, or being struck by a motor vehicle. The findings included: 1. Record review of Resident #1's Admission record, dated 01/15/25, reflected a [AGE] year-old male with admitted [DATE] and discharge date [DATE]. It reflected Resident #1 had diagnoses to include alcohol abuse with intoxication delirium (a mental state in which you are confused, disoriented, and not able to think or remember clearly) and alcohol dependence with alcohol-induced persisting amnesic disorder (a disturbance in memory). Record review of Resident #1's BIMS assessment, dated 09/04/24, reflected a score of 10 out of 15, indicating moderate impairment. Record review of Resident #1's Baseline Care Plan assessment, dated 08/30/24 and created by ADON B, reflected no answers for sections 3. Health Conditions . B. Level of Consciousness/Cognition . H. Safety Risks . 9. Is the resident an elopement risk?, mental health needs, and behavioral concerns. (continued on next page)		

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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 - Some	Record review of Resident #1's Elopement Risk Assessment, dated 08/31/24, reflected Resident #1 was Moderately impaired-decisions poor; cues/supervision required with One or more times [previous attempts to leave residence/facility] in the last week. It further revealed Resident #1 did not recognize stop lights and signs, did not know precautions when crossing streets, did not know location of current residence, did not know location of current residence, and did not recognize physical needs. The assessment further revealed he was at high risk for elopement and Wanderguard appropriate at this time-initiate wanderguard interventions. Record review of Resident #1's September 2024 MAR, dated 01/15/25, reflected: VISUAL CHECK EVERY 2 HOURS . for elopement risk with a start date of 08/31/2024. WANDER GUARD CHECK PLACEMENT EVERY SHIFT . with a start date of 09/04/24 and D/C Date of 09/10/24. Record review of Resident #1's hospital documents, dated 08/30/24, revealed Resident #1 was admitted to the hospital on 08/20/24. The hospital documents reflected Resident #1 comes into the ED today from the local jail for altered mental status . He was going through alcohol detox and thought related to his detox but he complete(d) the program today and still was not in a normal mental status. [Resident #1] is disoriented and can give his name but not his date of birth, the current year, where he is. Record review of Resident #1's Nurse's Note, authored by LVN C, dated 08/31/24 at 01:28PM, reflected Resident has attempted to get out of the back doors to the facility several times this shift. He states that he wants to go home . Obtained new order from PCP for medications to assist with anxiety and added 2 hour location checks to charting. Resident continues to insist that he has to leave. Record review of Resident #1's progress notes in PCC reflected no mention of Resident #1 leaving the facility on 09/04/24. Record review of a statement provided by the DON AK, authored by the DON AK, undated, reflected, I was notified by [ADON B] that [Resident #1] was no longer in the facility, facility was searched and head count was done to ensure other residents were all accounted for. Every resident with the exception of [Resident #1] was accounted for. Sign out book was checked, resident had not signed out. When facility and property was checked, it was noted that pillows and personal effects were placed on an employee's car. Family, administration and authorities were notified. [Received] notification from authorities that resident was pulled over in a vehicle (that did not belong to him) and taken to (another town) for further detainment. [Administrator G] went to pick up resident and brought him back to facility. Full body assessment done per [DON AK]. No injuries or discolorations noted at this time. No s/s of distress. Resident was apologetic for leaving without notifying anyone. [Resident #1] was alert and oriented and knew what he was doing was wrong but continued to leave the facility [without] signing out. Resident suffers from alcoholism which causes some disorganized thinking processes. Resident was able to explain what roads he took to get to where he was at and that he took a car without permission. Resident was safely brought back to facility via [Administrator G] and was encouraged to enter a detox center. Resident agreed and was ultimately safely discharged to another facility that specializes in detox from substance abuse. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/15/25 at 12:45 PM, Resident #1's RP revealed Resident #1 was confused but she did not know how confused or how bad his condition was after his hospital stay, several weeks before admission. She revealed the facility should have Resident #1's hospital documentation to reflect his mental status. She revealed she did not want to get the facility in trouble because it was her fault that she didn't realize what his new baseline mental status was. She revealed she would think the facility would have assessed Resident #1 to know how to care for resident and should have kept eyes on Resident #1 to prevent him from leaving the facility as she found out that his mental status was poor, after Resident #1 left the building. Resident #1's RP did not reveal any details about where the resident was found but the administrator had to drive to pick up Resident #1 from another location. During an interview on 01/15/25 at 01:17PM, RN A revealed she did not do the 4 AM check on 09/04/24 , which was a part of the doctor's orders to check on Resident #1 every 2 hours. RN A revealed when the morning shift was coming into the facility, they saw clothes that had Resident #1's name on them. RN A went to Resident #1's room and he was gone. During an interview on 01/15/25 at 02:45PM, LVN F revealed she knew Resident #1 was an elopement risk due to his behavior from the previous day. She revealed the nursing staff found Resident #1 was not in his room when the 6AM staff came in for their shift. The nursing staff searched inside and outside of the facility and found Resident #1 was no longer on the premises. LVN F revealed she called Administrator G and another nurse (unidentified) called the DON. She revealed Administrator G instructed her to call the local police department to report a missing person. LVN F could not identify what staff member called the local police department. She revealed Administrator G found out Resident #1 was in another town about an hour's drive away from the facility went to pick him up, brought Resident #1 back to the facility, and worked on placing Resident #1 in a different facility this same day. LVN F revealed she felt this incident was considered an elopement, however, LVN F was corrected by Administrator G this was not an elopement because Resident #1 could explain what and why he left the facility. LVN F further revealed she recalled Resident #1 did not have a wander guard bracelet on because there were not enough wander guard bracelets available at this time. LVN F revealed she was not trained on elopements or wandering after this incident . LVN F knew what to do for residents who wandered or were at risk for elopement. During an interview on 01/16/25 at 06:35 AM, the CDM revealed after the incident involving Resident #1, the dietary department was trained on elopement and signed a sheet someone from the nursing department handed them. She further revealed her whole department signed a sheet to prove they got trained. (This sign-in sheet was not able to be produced by the facility.) (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/16/25 at 08:13 AM, the DON revealed Resident #1 did not elope but left AMA because he had intact cognition but presented with disorganized thinking due to his alcoholism. She revealed she was told by nursing staff that Resident #1 was not in his room during a visual check. She revealed Resident #1 was on visual checks because she thought it was good protocol to have him on visual checks because he had disorganized thinking. She further revealed Resident #1 did not sign out on pass and he had doctor's orders to go out on therapeutic pass. The DON revealed she did not know if Resident #1 was capable of driving a car. She revealed she did not know if Resident #1 was an elopement risk but an elopement risk assessment would let the staff know. She revealed when Resident #1 was not in his room, they did a head count, and they couldn't find him on the premises. The DON revealed at this point, he was considered missing and they called the authorities, PCP, RP, and Administrator. When they called the authorities, they found him at another town's police department. She revealed the family who owned the car Resident #1 took from the nursing home parking lot did not decide to press charges against Resident #1. The DON revealed she started working at the facility in May 2024. She revealed staff were trained on wandering and elopement before this incident. She revealed Administrator G stated corporate risk management team did not consider this an elopement and the facility was advised not to report this incident to HHSC. She further revealed Administrator G said risk management advised the facility not to document in PCC and to do a soft file (physical copy) of this incident to include assessments of Resident #1. The DON revealed she trained everyone face to face, but she did not have a staff roster when training her clinical staff to train all of these staff members. The DON revealed if she did not get to train nursing staff, she left it in the binder where nurses signed in for their shift. She further revealed the nursing staff know to read what she puts in the binder and sign off that they read the pertinent documents. The DON revealed she only trained her department and no other departments. She further revealed she did not train the office staff. During an interview on 01/16/25 at 01:40PM, Confidential Staff N revealed they heard no one was going to report when Resident #1 eloped and was found in a different city about an hour away. They further revealed ADM G picked Resident #1 and brought him back to the facility but was not aware of anything else. They revealed they were told not to report this incident to HHSC because the facility was going to handle this incident a different way. During an interview on 01/16/25 at 02:37PM, ADM G revealed Resident #1 had alcohol induced dementia. ADM G revealed Resident #1 told him he looked out the window one night and thought he saw his wife's car and it was time to go home. ADM G revealed he remembered the facility staff called him, the police were involved, they tracked his phone, and the authorities had pulled him over in another town about an hour away. ADM G revealed he drove to the town to pick Resident #1 up from the police station. He revealed Resident #1 did not know where he was going. He revealed they had a conversation with the facility's ownership immediately about this incident. ADM G further revealed he thought this incident was reportable. ADM G revealed the COO gave them direction to not report this incident to HHSC. ADM G revealed Resident #1 did not have a wander guard bracelet. He revealed the front doors going outside did not lock overnight. He revealed he remembered knowing this was an issue, figuring out how to prevent residents from leaving the facility overnight. ADM G after he picked up Resident #1 he filled out a self-report form, in-serviced some staff about ANE and elopement and was still working on this. He revealed he started the paperwork as soon as he came into the building because he knew he was on the clock to complete in order to report to HHSC. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/16/25 at 04:16PM, the Medical Director revealed Resident #1 was at risk for elopement and he requested for everything to be done before Resident #1 left the building on 09/04/24. He further revealed he was contacted after this incident and the expectation was to ensure Resident #1 did not leave the facility for the resident's safety. 2. Record review of Resident #2's Admission record, dated 01/15/25, reflected an [AGE] year-old male with admitted [DATE] and discharge date [DATE]. It reflected Resident #2 had diagnoses to include dehydration, altered mental status, muscle weakness, abnormalities of gait or mobility, lack of coordination, dementia (condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking), and depression. Record review of Resident #2's Care Plan, close date 09/09/24, reflected focus The resident is an elopement risk/wanderer r/t impaired safety awareness, initiated 08/15/24 with interventions to include WANDER ALERT bracelet check placement and functioning q shift. Record review of Resident #2's August 2024 MAR, dated 01/15/25, reflected: WANDER GUARD CHECK FOR FUNCTION EVERYDAY. with a start date of 08/14/24 and D/C Date 09/03/24, filled out appropriately for day and night shifts. VISUAL CHECK EVERY 2 HOURS with a start date of 08/14/24 and D/C Date 09/03/24, filled out appropriately. Record review of Resident #2's Elopement Risk Assessment, dated 08/14/24, reflected Resident #2 was Moderately impaired-decisions poor; cues/supervision required with One or more times [previous attempts to leave residence/facility] in the last week. It further revealed Resident #2 did not recognize stop lights and signs, did not know precautions when crossing streets, did not know location of current residence, did not know location of current residence, and did not recognize physical needs. The assessment further revealed he was at high risk for elopement and Wanderguard appropriate at this time-initiate wanderguard interventions. Record review of Alert Note, authored by AD, dated 08/22/24 at 12:06PM, reflected, AD finished exercise group in main dining room and on the way back to AD office alarm in activities room was going off. AD looked out the outside door to make sure no one had gone out. Upon looking down the sidewalk resident was spotted going down looking (sic) at cars. She thought her son was out there. AD approached and redirected resident back to building and inside. AD and resident went to find the charge nurse to let her know about the adventure. [DON] was at the nurse's station as well, so she is (sic) aware of the incident. Record review of Resident #2's progress notes and assessments reflected no skin assessments were done after Resident #2 was found outside of the facility on 08/22/24 around 12:06PM. During an interview on 01/15/25 at 12:15 PM, LVN E revealed if a resident left the building and there were no eyes on the resident, she would complete a skin assessment on resident. After reading the alert note on 08/22/24 at 12:06PM, LVN E revealed she would have done a skin assessment on Resident #2 because Resident #2 exited the building and it appeared there was some time where a staff member wasn't with Resident #2. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/16/25 at 08:13 AM, the DON revealed Resident #2 was found on the facility sidewalk by the AD. She revealed Resident #2 was still on property and this incident was not reported because Resident #2 was on the premises. During an interview on 01/16/25 at 01:05PM, the AD revealed she had heard the door next to her office sound, so she went to check to see if a resident had left the building. She revealed Resident #2 was observed walking on the sidewalk between the nursing home parking lot (on her left) and the facility building/yard (on her right). The AD revealed Resident #2 was able to walk past 3 trees on the right side of her before she laid eyes on Resident #2. The AD revealed she was able to go outside and redirect Resident #2 to come back into the facility. The AD revealed she was trained on elopement this morning and had already been trained prior to this morning. During interview on 01/16/25 at 10:57 AM, the DON revealed there were no skin assessments done for Resident #2 on or after 08/22/24. 3. Record review of Resident #3's Admission record, dated 01/15/25, reflected a [AGE] year-old female with admitted [DATE] and discharge date [DATE]. It reflected Resident #3 had diagnoses to include abnormalities of gait and mobility, repeated falls, lack of coordination, muscle weakness, hypertension (high blood pressure), and dementia. Record review of Resident #3's Care Plan, close date 03/20/24, reflected focus The resident is an elopement risk/wanderer r/t impaired cognition Dementia wandering about in wc not easily redirected . 3/17/24 eloped from facility, located and easily redirected back to facility . 3/13/24 eloped out front doors to sidewalk easily redirected back into facility, initiated 02/07/24, with interventions to include WANDER ALERT bracelet applied check placement and function q shift, initiated 02/13/24, careplan meeting pending for alternated placement for secure unit for safety, initiated 03/14/24, 1:1 initiated, still attempting to assist family to find a suitable secured unit for her safety, initiated 03/18/24. Record review of Resident #3's March 2024 MAR, dated 01/15/25, reflected: WANDER GUARD CHECK PLACEMENT EVERY SHIFT, with a start date 02/12/24 and D/C date 03/25/24, filled out appropriately for day and night shifts. WANDER GUARD CHECK FOR FUNCTION EVERYDAY, every shift with a start date 02/12/24 and D/C Date 03/25/24, filled out appropriately for day and night shifts. Record review of Resident #3's Elopement Risk Evaluation V 2.0, dated 03/13/24, reflected Resident #3 was at risk for elopement. Record review of Resident #3's admission MDS assessment, dated 02/12/24, reflected Resident #3 had a BIMS score of 05 out of 15, indicating severely impaired cognition. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of written statement in intake 491104's investigation provided by the facility, undated, by COTA J reflected I was alerted by [Unidentified resident] that [Resident #3] was outside. [unidentified resident] stated that she saw her walking down a road opposite direction of our building from her window. I immediately found [LVN F] to alert her of [Resident #3] being outside. We both left the building to look in the direction of where [unidentified resident] last saw her go. [LVN F] was able to quickly locate [Resident #3] and guide her back to the building. Record review of written statement in intake 491104's investigation provided by the facility, dated 03/17/24, by DON K reflected .[Resident #3] continues on [every 15 minute] checks that were initiated Friday, 3/15/24 . [LVN F] reports wanderguard device has been alarming appropriately but they did not hear any door alarm with her last exit from the [building]. She is unsure why there was no alarm sounding when she went to retrieve her through the front door exit. During an interview 01/15/25 02:02 PM, the Business Office Manager was not aware if she was trained on elopements. She revealed she would contact the Administrator or the DON if she saw a resident leaving the facility. She revealed she would try to redirect the resident and try to stop the resident from leaving the facility. She would try to get help, even calling someone while trying to help resident. During an interview on 01/15/25 at 03:14 PM, RN H revealed she had received an in-service on wander guards and what to do for residents who wandered but had not been trained on elopements. She revealed it would be a good idea to be trained on elopements because she was not aware of how to help her coworkers if an elopement occurred. RN H stated rhetorical questions (questions to make a point rather than to get an answer) like Do we notify the doctor or RP?. She revealed she was present when Resident #1 eloped and stated she was not asked for a witness statement, which she felt would be the procedure for this incident to figure out how this resident left the building. Observation 01/16/25 at 04:32AM revealed the facility's front door was locked from the outside. However, it was revealed the doors were not locked going from the inside of the facility to the outside of the facility. During an interview and observation on 01/16/25 at 04:38AM with ADON B, ADON B revealed there were 2 doors to open before accessing the outside, in the front of the building. The first door had a machine attached to the door that should lock the doors if a resident with a wander guard bracelet approached the door. She further revealed if a resident had a wander guard the first door should lock itself to prevent these residents from walking outside, however, if the 1st door was held open for 15 seconds, then the resident could walk out but the alarm will continue to sound. She revealed when the alarm sounded, the staff would look to see what exit was alarming to investigate if a resident left the building or not. She further revealed the second and last door that goes to the outside did not have an alarm. ADON B revealed residents without wander guards could open both doors to exit the front of the building without any alarms sounding. ADON B further revealed if a resident was allowed to go out on pass and wanted to leave, they would have to sign out with staff. She revealed there were no current residents that sign out on pass during the overnight shift. During an interview on 01/16/25 at 05:27AM, the current administrator (Administrator I) revealed if there was a confirmed elopement or abuse, neglect, exploitation, he would print the current staff roster and train 100% of all facility staff members. He revealed he would be important for all staff to know what to do in the case of these situations. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a combined interview on 01/16/25 at 05:51AM, RN A and CNA D revealed they did not recall being trained about topics that included elopement or residents who wander after the incident where Resident #1 left the facility. RN A revealed she did know a little bit of what to do if a resident eloped and she would check all the rooms and outside of the facility if the door alarmed. CNA D revealed those residents with wander guards would alarm the door if they opened the door to exit the facility. RN A revealed she knew what residents were at risk for elopement because it popped up on her point of care screen. CNA D revealed she knew residents were at risk for elopement if they were wearing a wander guard, but it did not show her on her point of care screen. During an interview on 01/16/25 at 01:54PM, OT AQ revealed since February 2024, she had not received any training to include elopement and Abuse, Neglect, and Exploitation. She was educated on Elopement this morning to include pay attention to exit seeking behaviors. During an interview on 01/16/25 at 04:09PM, COTA J revealed Resident #3 left the building and walked down the road and about 1 to 2 blocks away from the facility before an unidentified resident told her they saw Resident #3 outside. She revealed she did not recall how Resident #3 got out and that the door alarms did not sound when resident left the building. She revealed she was trained on elopement before this incident and refreshers after . Record review of in-service about policy Wandering and Elopements, dated 03/17/24, reflected 20 staff were in-serviced. Requested staff roster for 03/17/24 on 01/15/25 at 09:50AM and no staff roster was able to be provided. Record review of in-service, undated, titled Elopement Risk Residents/Q2hr checks, reflected 8 nurses were in-serviced. The summary of this in-service reflected, As nurses, we need to make sure we are constantly laying eyes on our residents especially our elopement risk residents. Rounds must be made at the very least, 2hrs, if not sooner. It is our responsibility to keep our residents safe. It is of the utmost importance that we are correctly documenting our 2hr checks on these resident and appropriately documenting exit seeking behaviors. This is not an option. An Immediate Jeopardy (IJ) was identified and presented to Administrator I on 01/16/25 at 05:45 PM. A Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 01/17/25 at 06:19 PM. 1) Resident #1, Resident #2 and Resident #3 no longer reside in facility. 2) DON Inserviced all staff on elopement policy, 1/16/2025 those who cannot be reached by telephone will be in-serviced when they return to work before taking the floor, by DON. This will be ongoing process and new hire employees will be in-serviced on elopement policy during hire process. 3) Maintenance to verify all wanderguards in use in facility are functional 1/16/25. This was completed 01/16/25. Verified by administrator. Maintenance will make these checks daily Monday thru Friday and nursing staff makes the checks on weekends. These daily wanderguard checks are documented in Point Click Care Nurse Medical Administration Record. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4) Maintenance to verify all doors with wanderguards or alarms are functional this was completed 1/16/25 verified by the administrator. Door locks are checked Monday through Friday by Maintenance. Maintenance documents on his written log. Doors with wanderguard alarms alert and locks the door when resident with wanderguard approaches. Doors with wanderguard system do not alert if staff or visitors open door. Doors with other exit alarms alert when staff, residents or visitors open door. The front door also has the receptionist observing during business hours. When the receptionist leaves the doors are unlocked for staff and visitors but lock automatically with approach of resident with wanderguard. The facility monitors doors after hours by staff responding to alarms. A visitor exiting and a resident behind them with a wanderguard still sets off the alarm as witnessed by Surveyor. Staff responds to door alarms to ensure the safety of residents who wander. Front double door doors will be locked with keypad. Staff will unlock for visitors to enter or exit. 5) Updated elopement assessment on all current residents 1/16/25. Completed by DON, ADON, and MDS nurse. Residents with wanderguards are identified for staff in the front of the elopement binder, on the home dashboard of Point Click Care and the Kardex. Residents may be at high risk for elopement but not actively exit seeking. Until we see exit seeking behavior, they would not be deemed appropriate for an actual wander guard. At the bottom of the elopement risk assessment, it asks if a wanderguard is indicated. If the answer is yes then we would apply a wanderguard. Nurses in-serviced on 1/17/2025 by Administrator to ensure that checks ordered by physician are completed and documented timely. Nurses not in facility today will be in-serviced before they begin their next shift in the facility, this will include new hires. Interdisciplinary team will review elopement assessments that trigger for high risk to determine if a wander guard is warranted. 6) Residents with wanderguards have current orders, careplan and elopement assessment. Completed by ADON on 1/16/25 7) Elopement binders equipped with all high risk for elopement resident facesheets at the front, and all other residents facesheets behind the tab were placed at the nurses station and at the receptionist desk by the DON/Administrator. 8) Staff were inserviced by BOM regarding the elopement binders, where they are located, and how to use them on 01/16/2025. 9) The administrator inserviced on 1/16/2025 the DON and ADON to update the facesheets in the elopement binder with any new admission, or change in elopement risk from low risk to high risk. All nursing staff were inserviced on the elopement policy, including all assessments and notifications to RP and provider that are required, by the DON on 01/16/2025. All nursing staff will receive the inservice prior to starting their next shift. 10) All residents at high risk for elopement will be identified on the C NA Kardex. This inservice will be delivered by the DON to all staff on 01/16/2025. All staff will receive this inservice prior to starting their next shift. 11) All residents who are at high risk for elopement will be added to the home dashboard on the EMR by the DON on 01/16/2025. An inservice will be provided by the DON on 01/16/2025. All nursing staff will receive this inservice prior to beginning their next shift. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455941	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2025
NAME OF PROVIDER OR SUPPLIER Enchanted Rock Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 210 West Windcrest St Fredericksburg, TX 78624	
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 - Some	12) Facility completed internal investigations on the three elopement incidents. 13) Medical Director informed of IJ on 1/16/2025 by Administrator 14) Ad Hoc QAPI, 1/16/2025 reviewed the IJ, What occurred and what the facility has in place to prevent it from recurring. POR verification was as follows: Record review of facility's discharge list, dated 01/17/25, reflected Residents #1, 2, and 3 were discharged . Resident #3 discharged home on 3/18/24; Resident #1 discharged home on 9/4/24; and Resident #2 discharged to an ALF on 9/3/24. Record review of facility's in-service sheets dated 01/16/25 at 5:45 PM to 01/17/25 at 5:30 PM reflected: 41 staff working had been in-serviced on elopement (100% training rate). Total paid staff was 65. Record review of Logbook Documentation, dated 01/16/25-01/18/25, reflected all doors passed for magnetic door locks(100 hall, 200 hall, 300 hall, 300 hall service door, 400 hall, family room, front door, main dining room, small dining room, therapy rehab gym) and resident monitoring system (400 hall, therapy rehab gym, front door, and Residents #4-10). Record review of the home dashboard of Point Click Care, posted 01/16/25, reflected: Residents at High Risk for Elopement: Resident #4 Resident #5 Resident #6 Resident #7 Resident #25 Resident #24 Resident #23 Resident #22 Resident #21 Resident #20 Resident #19 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455941	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2025
NAME OF PROVIDER OR SUPPLIER Enchanted Rock Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 210 West Windcrest St Fredericksburg, TX 78624	
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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 - Some	Resident #18 Resident #9 Resident #10 Resident #26 Resident #16 Resident #15 Resident #13 Resident #12 Resident #8 Resident #14 Resident #17 Resident #11 Record review of facility's high risk elopement list included Resident #11 to Resident #26 whose scores were 10 or above, indicating high risk for elopement on their respective elopement risk assessments, dated 01/16/25: Record review of the 7 residents with wander guard orders (Resident #4 to Resident #10) reflected: care plans listed elopement with interventions, MD orders approved wander-guard and elopement assessments present. Record review of AD HOC QAPI sign in sheet, reflected a QAPI meeting was held on 01/16/25. Observation on 01/17/25 at 08:11PM revealed the Administrator (ADM I) had to let out this Investigator from the building after punching in a code into the keypad. Observation and record review on 01/18/25 at 08:40AM revealed a sign on the front door reflecting Inside Door Locked Please use doorbell. After going through the first front door and approaching the second door to get into the facility, it was observed the Maintenance Dire [TRUNCATED]		