STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675469	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Floresville Residence and Rehabilitation Center	1811 Sixth St Floresville, TX 78114

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 34469

Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #s 1 and 2) of 5 residents reviewed for abuse, neglect, and misappropriation of property, in that;

1. The facility failed to report Resident #1's 5/7/2024 elopement to HHSC.

2. The facility failed to report Resident #2's 5/2/2024 elopement to HHSC.

This failure could place residents at risk for not having incidents reported as required and continued neglect which could result in diminished quality of life.

The findings were:

1. Record review of Resident #1's face sheet revealed she was admitted on [DATE] and was [AGE] years old. Resident #1's diagnoses included: tachycardia (When you have tachycardia, your heart beats too fast -- more than 100 beats per minute when you're at rest), and dementia.

Record review of Resident #1's MDS (Entry 5/7/2024) revealed no BIMs score.

Record review of Resident #1's electronic chart, under Assessments, revealed a document titled, Elopement Risk - Change of Status, dated 5/7/2024. Further review revealed Resident #1 was at risk for elopement with a score of 12 (High Risk), specifically that she, Verbalizes desire or plan to leave the facility unauthorized/unsupervised (10 pts.), and, Ambulatory (2 pts.)

Record review of Resident #1's Progress Note, dated 5/7/2024 at 7:19 PM, stated,**Nurses Note** Note Text: Notified RP and Physician of (Resident #1's) elopement. RP was thankful resident is ok and moving to memory care. Resident and belongings moved to memory care per (ADON K).[sic]

(continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER: Floresville Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1811 Sixth St Floresville, TX 78114	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Incident's and Accidents report, printed 5/9/2024, revealed no documented incidents related to Resident #1, specific to elopement. Interview on 5/10/2024 at 1:38 PM, the Administrator confirmed Resident #1 eloped from the facility on 5/7/2024 and opioned the elopement could have occurred while the front door was left unattended during resident smoking time. The Administrator indicated the person at the front desk was responsible for escorting residents to and from the smoking area during their smoke breaks which could at times leave the entrance unstaffed. The Administrator said facility staff would be instructed to ensure someone would remain at the entrance at all times until the doors locked in the evening in response to Resident #1's elopement. Interview on 5/10/2024 at 3:50 PM, CMA B said it was around 6:00 pm on 5/7/2024 when staff discovered Resident #1 was missing. CMA B said LVN K got a phone call and then started pacing around looking out the windows. CMA B said she saw Resident #1 walking through the grass in someone's yard approximately 4 blocks away from the facility near a busy street where 18 wheelers travel at a high rate of speed. CMA B said Resident #1 recognized her and got in the car with her to go back to the facility. CMA B Resident #1 was sweating and looked tired and said she didn't know where she was, that she was lost. Upon returning to the facility, CMA B got the Resident #1 a glass of water. CMA B said a high school-aged family member of one of the dietary staff the reported she saw Resident #1 depart the facility from the front door after she noticed the resident being returned to the facility. When asked if anyone was monitoring the front door at the time of Resident #1's disappearance, CMA B said the front door monitor would take the residents to a different location during their designated smoke break and said that it's always a big hassle. CMA B said it was warm that day and that her .car's temperature gauge showed the temperature was 91 F after her shift ended that day. When asked how staff would be informed of the identity of new residents, CMA B said she was unsure and that some residents are admitted at random times, and stated that it was difficult to identify newly admitted residents. 2. Record review of Resident #2's facesheet (printed 5/8/2024) revealed she was admitted [DATE] and discharged [DATE] and was [AGE] years of age. Resident #2's diagnoses included: senile degeneration of the brain (also known as Senile dementia is the mental deterioration (loss of intellectual ability), Alzheimer's disease, copd, depression, insomnia, hypertension, gastro-esoph reflux, and an over-active bladder. Record review of Resident #2's electronic chart, MDS (entry), dated 4/29/2024) revealed no BIMs Score. Record review of Resident #2's progress note on date, 5/3/2024 at 10:00 AM, stated, Late Entry: Note Text: Received call from (biological family member) of (Resident #2) requesting to speak to and come visit resident at facility. This nurse placed call to RP, spouse, whom gave verbal permission for son to speak to and visit resident inside facility.[sic] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of Resident #2's progress note dated, 5/3/2024 at 5:41 PM, stated, Late Entry: Note Text: Notified by staff that they were unable to locate (Resident #2) after dinner. This nurse along with other ADON and staff attempted to locate (Resident #2). Per charge nurse, (Resident #2's biological family member) was in the facility and given permission by RP to visit with (Resident #2) inside facility. Called RP and informed resident was not able to be located. Called number for (Resident #2's biological family member) given by RP. Was informed it was the wrong number. Police notified and in facility. CNA stated she witnessed son in the facility with a bag of (Resident #2's) belongings. All belongings gone from room. Notified by another staff member that she witnessed (Resident #2) walking down the hall hand in hand with (Resident #2's biological family member). All this information given to RP and police officer in facility. Administrator, PCP, and RP updated on current situation. Late Entry:

Note Text: (Resident #2) was reported possibly missing at 1715 to this nurse by CNA as she was attempting to serve her dinner. This nurse notified ADON immediately and began checking every room in the north wing. This nurse checked residents closet and clothes were gone.

Record review of Resident #2's progress note dated 5/3/2024 at 8:42 PM stated, Note Text: Reported to (RN L) regarding incident with (Resident #2). (RN M) Executive Director called to confirm and asked that this facility f/u with any new information.

Record review of Resident #2's progress note dated 5/4/2024 at 2:34 PM, stated: Late Entry:

Note Text: At approximately 1:45 PM on 5/4/24 I received a call from (Off N) in regard to (Resident #2). Case # 2400898/ [PHONE NUMBER](phone #). He stated that (Resident #2) is safe and is with (Resident #2's biological family member). (Resident #2) has been checked out by the local EMS personnel and is in good health and spirits. He also stated all missing person's bulletins have been cancelled. There will not be any kidnapping charges filed nor any other charges since she is with (Resident #2's biological family member). Number to Hospice provided per his request. (Off N) stated (Resident #2's biological family member) has already obtained all her medications as well.

Record review of a document, titled, Medical Power of Attorney Designation of Healthcare Agent, signed by Resident #2 on 11/15/2023, revealed the Resident #2's (biological family member) was designated as First Alternate Agent.

Record review of the facility's Incident's and Accidents report, printed 5/3/2024, revealed no documented incidents related to Resident #2, specific to elopement.

Interview on 5/13/2024 at 2:48 PM, the Administrator stated Resident (Resident #2) was removed from the facility by biological family member 5/3/2024, and was subsequently taken to his home. The Administrator indicated there was an ongoing family dynamic between the biological family of Resident #2 and the non-related children of her husband. The Administrator stated the police were called by the facility when they discovered Resident #2 was missing. The Administrator stated Resident #2 was no longer residing at the facility and her RP was issued a reimbursement.

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NAME OF PROVIDER OR SUPPLIER Floresville Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 Sixth St Floresville, TX 78114	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/13/2024 at 3:40 PM, Witness, LVN C said she was at the facility at the time Resident #2 left the facility. LVN C said she was asked by staff if she had seen Resident #2 pass her as Resident #2 was unable to be located. LVN C said she spoke to the a police officer near (Resident #2's biological family member's home) the following day and said Resident #2 had been assessed by EMS and had no injuries, was not in distress, and was with (Resident #2's biological family member) and was safe. LVN C said police informed her the case was cancelled and asked for the Resident #2's hospice information and spoke to her hospice agency. LVN C said on the day of the incident, (Resident #2's biological family member) was visiting. LVN C said Resident #2's dementia was getting progressively worse which was why she was admitted to the facility. When asked why the (Resident #2's biological family member) wasn't on the resident's face sheet as a contact she said it was likely because her (non-biological family members) were involved with placing Resident #2 at the facility. Interview on 5/13/2024 at 3:55 PM, ADON E, stated the facility was contacted by a nurse (name unknown) who said Resident #2 was not in her room and her room was empty. ADON E said staff made all necessary notifications and said one of the staff said they saw Resident #2 walking down the hall, holding hands. ADON E further stated another staff, CNA G, was said to have seen the (Resident #2's biological family member) walking out of the facility with a large bag. Telephone interview on 5/13/2024 at 4:02 PM, Resident #2 Emergency Contact said Resident #2 was taken illegally, and was said to still be residing with (Resident #2's biological family member) Interview on 5/13/2024 at 4:11 PM, CNA G said she saw (Resident #2's biological family member) come into the facility and was visiting the Resident #2. CNA G said she left Resident #2's room to allow them privacy during their visit and said she later saw (Resident #2's biological family member) leaving the facility with a big blue bag but said she did not think anything of it because residents' families would frequently take their clothing home to wash it. The CNA G said Resident #2 was pretty new at the time and said some staff may not have been aware of her identity. Telephone interview on 5/14/2024 at 9:44 AM, (Resident #2's biological family member) confirmed Resident #2 was with him and said she was currently at the hospital because she had blood on her brain, and that doctors are trying to dissolve it. When asked why he took Resident #2 from the nursing home (Resident #2's biological family member) responded, because she didn't want to be there. (Resident #2's biological family member) further stated that Resident #2's RP, .put her in the facility without her (biological family's) consent, and that Resident #2's RP, . took all of her belongings and sold them or gave them away. Interview on 5/14/2024 at 10:47 AM, the Administrator confirmed Resident #2 was not signed out of the facility prior to her leaving the facility's property and was unaccounted for during a period of time. Telephone interview on 5/14/2024 at 11:35 AM, Resident #2's Responsible Party revealed he had not talked to Resident #2 since she left the facility with (Resident #2's biological family member) The RP said Resident #2's biological family, .are crazy sons' of bitches. The RP further stated Resident #2 had Alzheimer's disease, that she had, good days and bad days, that they had been married over [AGE] years and, .she is the love of my life. The RP stated Resident #2's hospice agency had filed a report with Adult Protective Services. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/14/2024 at 4:30 PM, the facility's Social Worker stated the facility had a protocol for residents leaving the facility which included checking with the charge nurse, documenting the time and who the resident is leaving with, and ensuring authorization with the resident's responsible party. Interview on 5/14/2024 at 4:32 PM, Health Screener (HS) J stated she was monitoring the facility's front door during the time and date of Resident #2's elopement. HS J said her job was to greet and screen individuals entering and exiting the facility. HS J said that during the time of Resident #2's elopement, she was monitoring residents in a different location, the smoking area, and returning them to their rooms afterward. HS J said the front entrance was not being monitored during this time but said there had been recent changes requiring staff to be at the front door at all times while the entrance is unlocked. Interview on 5/14/2024 at 4:50 PM, ADON E was asked where Resident #2 resided on the day of her elopement and stated Resident #2 was on 500 Hall. When asked why Resident #2 was not in a secured unit given her Elopement Assessment indicated she was at risk, ADON E responded that Resident #2 did not present with a history of exit seeking or wandering behaviors. Interview on 5/15/2024 at 10:00 AM, the Administrator, accompanied by the DON and ADON K, acknowledged that both Residents #1 and #2 had left the facility without the knowledge of facility staff and without adherence to the facility's policies and procedures. Record review of a facility policy, Titled, Abuse and Neglect,(no date), stated, If abuse/neglect is suspected the facility will: 2. Notify the appropriate/designated organization/authority HHSC that an investigation is being initiated immediately following intervention for the resident's safety . Further review stated, Prevention (483.13 (b) and 483.13 (c): Have procedures to: Ensuring health and safety of residents in regards to visitors.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34469 Based on interviews and record reviews, the facility failed to ensure residents received adequate supervision to prevent elopements for 2 of 5 residents (Residents #1 and #2) reviewed for accidents and supervision, in that: 1. The facility failed to provide adequate supervision to Resident #1. As a result, Resident #1, who had dementia, eloped from the facility on 5/7/2024 and was unaccounted for after approximately 5:45 pm. Resident #1 was discovered to be walking approximately 4 blocks from the facility near a busy street at approximately 6:10 PM. The weather for that day at around that time was in the upper 80s F and Resident #1 was purported to say she was thirsty and lost and was seen to be visibly perspiring. 2. The facility failed to provide adequate supervision to Resident #2. As a result, Resident #2, who had Alzheimer's Disease, eloped from the facility on 5/3/2024 and was unaccounted for after approximately 5:15 PM. The facility was notified by law enforcement on 5/4/2024 the resident was discovered to be with a family member who did not have consent by Resident #2's responsible party to be discharged from the facility. These failures resulted in the identification of an Immediate Jeopardy (IJ) on 5/10/2024 at 5:55 PM. While the immediacy was removed on 5/12/2024 at 5:27 p.m., the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility's need to monitor the implementation of the plan of removal. This failure placed all residents at risk for serious injury, harm, and/or death due to lack of appropriate supervison. Findings included: 1. Record review of Resident #1's face sheet revealed she was admitted on [DATE] and was [AGE] years old. Resident #1's diagnoses included: tachycardia (When you have tachycardia, your heart beats too fast -- more than 100 beats per minute when you're at rest), and dementia. Record review of Resident #1's electronic chart revealed no care plan. Record review of Resident #1's MDS (Entry 5/7/2024) revealed no BIMs score. Record review of Resident #1's electronic chart, under Assessments, revealed a document titled, Elopement Risk - Change of Status, dated 5/7/2024. Further review revealed Resident #1 was at risk for elopement with a score of 12 (High Risk), specifically that she, Verbalizes desire or plan to leave the facility unauthorized/unsupervised (10 pts.), and, Ambulatory (2 pts.) Record review of Resident #1's Progress Note, dated 5/7/2024 at 7:19 PM, stated,**Nurses Note** Note Text: Notified RP and Physician of (Resident #1's) elopement. RP was thankful resident is ok and moving to memory care. Resident and belongings moved to memory care per (ADON K).[sic] (continued on next page)

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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 Progress Note, dated 5/7/2024 at 7:57, stated Skin/Wound Note Text: Weekly skin assessment completed. Noted: No current skin concerns noted. Finger nails are clean neat and trimmed. Toe nail are neat, clean and trimmed. Yes pain medication available. [sic] Record review of the facility's Incident's and Accidents report, printed 5/9/2024, revealed no documented incidents related to Resident #1, specific to elopement. Record review of a website, [Name of City] Weather History | Weather Underground (wunderground.com), revealed the temperature for 5/7/2024 at 5:15 PM was approximately 89 F. Observation on 5/9/2024 at 11:28 AM - Hall 100's entry/exit door opened without delay and the alarm did not sound. A photograph and video taken were recorded at this time. Interview and observation on 5/9/2024 at 11:29 AM. the Maintenance Aide confirmed the door on the end of hall 100 readily opened and no alarm sounded. The Maintenance Aide proceeded to depress a switch located at the top of the door frame which successfully armed the door alarm. The Maintenance Aide was asked if he understood the concern and responded that, You wouldn't know when a resident might walk off. The Maintenance Aide was asked why the door alarm was not armed and responded that staff may have been taking out the trash. When asked if any residents had recently left the facility without assistance, the Maintenance Aide responded that he was not aware. Interview on 5/10/2024 at 1:38 PM, the Administrator said some residents do sit on the front patio when accompanied by staff or family members and said the facility now ensures there is always someone at the front desk until the evening when the door locks but said prior to Resident #1's elopement, the front desk staff would take residents to the smoking area during smoke breaks. The Administrator said that her office and several other offices were near the front door as a back up to when the front door monitor would assist during smoke breaks. The administrator said there had been one family member that would shut off a door alarm on occasion and said she has talked to the family member about the concern and has staff checking the daily to ensure the door alarms are armed. Interview on 5/10/2024 at 2:32 PM, Resident #1's Responsible party stated he was not with Resident #1 when she eloped but said she was now in memory care where she belongs. Telephone interview on 5/10/2024 at 2:40 PM, LVN A stated she had just arrived at the facility after Resident #1 had eloped. LVN A stated she was told to do another elopement risk assessment for Resident #1 following her elopement. LVN A said the person who found Resident #1 was an LVN C who had just ended her shift and discovered the resident walking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/10/2024 at 3:50 PM, MA B said it was around 6:00 pm on 5/7/2024 when staff discovered Resident #1 was missing. MA B said LVN K got a phone call and then started pacing around looking out the windows. MA B said she saw Resident #1 walking through the grass in someone's yard approximately 4 blocks away from the facility near a busy street where 18 wheelers travel at a high rate of speed. MA B said Resident #1 recognized her and got in the car with her to go back to the facility. MA B Resident #1 was sweating and looked tired and said she didn't know where she was, that she was lost. Upon returning to the facility, MA B got the Resident #1 a glass of water. MA B said a high school-aged family member of one of the dietary staff the reported she saw Resident #1 depart the facility from the front door after she noticed the resident being returned to the facility. When asked if anyone was monitoring the front door at the time of Resident #1's disappearance, MA B said the front door monitor would take the residents to a different location during their designated smoke break and said that it's always a big hassle. MA B said it was warm that day and that her .car's temperature gauge showed the temperature was 91 F after her shift ended that day. When asked how staff would be informed of the identity of new residents, MA B said she was unsure and that some residents are admitted at random times, and stated that it was difficult to identify newly admitted residents. 2. Record review of Resident #2's facesheet (printed 5/8/2024) revealed she was admitted [DATE] and discharged [DATE] and was [AGE] years of age. Resident #2's diagnoses included: senile degeneration of the brain (also known as Senile dementia is the mental deterioration (loss of intellectual ability), Alzheimer's disease, copd, depression, insomnia, hypertension, gastro-esoph reflux, and an over-active bladder. Record review of Resident #2's electronic chart, MDS (entry), dated 4/29/2024) revealed no BIMs Score. Record review of Resident #2's electronic chart revealed no careplan. Record review of Resident #2's progress note on date, 5/3/2024 at 10:00 AM, stated, Late Entry: Note Text: Received call from (biological family member) of (Resident #2) requesting to speak to and come visit resident at facility. This nurse placed call to RP, spouse, whom gave verbal permission for son to speak to and visit resident inside facility.[sic] Record review of Resident #2's progress note dated, 5/3/2024 at 5:41 PM, stated, Late Entry: Note Text: Notified by staff that they were unable to locate (Resident #2) after dinner. This nurse along with other ADON and staff attempted to locate (Resident #2). Per charge nurse, (Resident #2's biological family member) was in the facility and given permission by RP to visit with (Resident #2) inside facility. Called RP and informed resident was not able to be located. Called number for (Resident #2's biological family member) given by RP. Was informed it was the wrong number. Police notified and in facility. CNA stated she witnessed son in the facility with a bag of (Resident #2's) belongings. All belongings gone from room. Notified by another staff member that she witnessed (Resident #2) walking down the hall hand in hand with (Resident #2's biological family member). All this information given to RP and police officer in facility. Administrator, PCP, and RP updated on current situation. Late Entry: Note Text: (Resident #2) was reported possibly missing at 1715 to this nurse by CNA as she was attempting to serve her dinner. This nurse notified ADON immediately and began checking every room in the north wing. This nurse checked residents closet and clothes were gone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's progress note dated 5/3/2024 at 8:42 PM stated, Note Text: Reported to (RN L) regarding incident with (Resident #2). (RN M) Executive Director called to confirm and asked that this facility f/u with any new information. Record review of Resident #2's progress note dated 5/4/2024 at 2:34 PM, stated: Late Entry: Note Text: At approximately 1:45 PM on 5/4/24 I received a call from (Off N) in regard to (Resident #2). Case # 2400898/ [PHONE NUMBER](phone #). He stated that (Resident #2) is safe and is with (Resident #2's biological family member). (Resident #2) has been checked out by the local EMS personnel and is in good health and spirits. He also stated all missing person's bulletins have been cancelled. There will not be any kidnapping charges filed nor any other charges since she is with (Resident #2's biological family member). Number to Hospice provided per his request. (Off N) stated (Resident #2's biological family member) has already obtained all her medications as well. Record review of a document, titled, Medical Power of Attorney Designation of Healthcare Agent, signed by Resident #2 on 11/15/2023, revealed the Resident #2's (biological family member) was designated as First Alternate Agent. Record review of the facility's Incident's and Accidents report, printed 5/3/2024, revealed no documented incidents related to Resident #2, specific to elopement. Interview on 5/13/2024 at 2:48 PM, the Administrator statedResident #2 was removed from the facility by biological family member 5/3/2024, and was subsequently taken to his home. The Administrator indicated there was an ongoing family dynamic between the biological family of Resident #2 and the non-related children of her husband. The Administrator stated the police were called by the facility when they discovered Resident #2 was missing. The Administrator stated Resident #2 was no longer residing at the facility and her RP was issued a reimbursement. Interview on 5/13/2024 at 3:40 PM, Witness, LVN C said she was at the facility at the time Resident #2 left the facility. LVN C said she was asked by staff if she had seen Resident #2 pass her as Resident #2 was unable to be located. LVN C said she spoke to the a police officer near (Resident #2's biological family member's home) the following day and said Resident #2 had been assessed by EMS and had no injuries, was not in distress, and was with (Resident #2's biological family member) and was safe. LVN C said police informed her the case was cancelled and asked for the Resident #2's hospice information and spoke to her hospice agency. LVN C said on the day of the incident, (Resident #2's biological family member) was visiting. LVN C said Resident #2's dementia was getting progressively worse which was why she was admitted to the facility. When asked why the (Resident #2's biological family member) wasn't on the resident's face sheet as a contact she said it was likely because her (non-biological family members) were involved with placing Resident #2 at the facility. Interview on 5/13/2024 at 3:55 PM, ADON E, stated the facility was contacted by a nurse (name unknown) who said Resident #2 was not in her room and her room was empty. ADON E said staff made all necessary notifications and said one of the staff said they saw Resident #2 walking down the hall, holding hands. ADON E further stated another staff, CNA G, was said to have seen the (Resident #2's biological family member) walking out of the facility with a large bag. Telephone interview on 5/13/2024 at 4:02 PM, Resident #2 Emergency Contact said Resident #2 was taken illegally, and was said to still be residing with (Resident #2's biological family member) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Floresville Residence and Rehabilitation Center	1811 Sixth St Floresville, TX 78114

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 5/13/2024 at 4:11 PM, CNA G said she saw (Resident #2's biological family member) come into the facility and was visiting the Resident #2. CNA G said she left Resident #2's room to allow them privacy during their visit and said she later saw (Resident #2's biological family member) leaving the facility with a big blue bag but said she did not think anything of it because residents' families would frequently take their clothing home to wash it. The CNA G said Resident #2 was pretty new at the time and said some staff may not have been aware of her identity. Telephone interview on 5/14/2024 at 9:44 AM, (Resident #2's biological family member) confirmed Resident #2 was with him and said she was currently at the hospital because she had blood on her brain, and that doctors are trying to dissolve it. When asked why he took Resident #2 from the nursing home (Resident #2's biological family member) responded, because she didn't want to be there. (Resident #2's biological family member) further stated that Resident #2's RP, .put her in the facility without her (biological family's) consent, and that Resident #2's RP, . took all of her belongings and sold them or gave them away. Interview on 5/14/2024 at 10:47 AM, the Administrator stated Resident #2 was not signed out of the facility prior to her leaving the facility and said Resident #2's RP and non-biological children requested a refund from the facility. Telephone interview on 5/14/2024 at 11:35 AM, Resident #2's Responsible Party revealed he had not talked to Resident #2 since she left the facility with (Resident #2's biological family member) The RP said Resident #2's biological family, .are crazy sons' of bitches. The RP further stated Resident #2 had Alzheimer's disease, that she had, good days and bad days, that they had been married over [AGE] years and, .she is the love of my life. The RP stated Resident #2's hospice agency had filed a report with Adult Protective Services. Interview on 5/14/2024 at 4:30 PM, the facility's Social Worker stated the facility had a protocol for residents leaving the facility which included checking with the charge nurse, documenting the time and who the resident is leaving with, and ensuring authorization with the resident's responsible party. Interview on 5/14/2024 at 4:32 PM, Health Screener (HS) J stated she was monitoring the facility's front door during the time and date of Resident #2's elopement. HS J said her job was to greet and screen individuals entering and exiting the facility. HS J said that during the time of Resident #2's elopement, she was monitoring residents in a different location, the smoking area, and returning them to their rooms afterward. HS J said the front entrance was not being monitored during this time but said there had been recent changes requiring staff to be at the front door at all times while the entrance is unlocked. Interview on 5/14/2024 at 4:50 PM, ADON E was asked why where Resident #2 resided and said Resident #2 was on 500 Hall. When asked why Resident #2 was not in a secured unit given her Elopement Assessment indicated she was at risk, ADON E responded that Resident #2 did not present with a history of exit seeking or wandering behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Floresville Residence and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1811 Sixth St Floresville, TX 78114	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of website, Elopement in Nursing Homes: Resident Elopement Risks (nursinghomesabuse. org), stated, According to the Alzheimer's Association, elopement or wandering are common issues among the elderly who have conditions such as Alzheimer's disease or other types of dementia. Residents who wander may have mental impairments and be unable to return home once they find themselves outside the facility. They may be confused about where they are or where they are going. For those with Alzheimer's disease, it is predicted that six out of 10 people will wander and become lost. Wandering can happen at any stage of Alzheimer's disease, early, middle, or late. Problematically, since people with Alzheimer's disease, mental impairments, or dementia may be confused about their location or other information, those who are not found within 24 hours are at a high risk of getting hurt or passing away. The Administrator was notified of an IJ on 5/10/2024 at 5:55 PM and was given a copy of the IJ template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on 5/12/2024 at 5:27 PM and included the following: 1. On 5-10-2024 at approximately 5:55pm (This Nursing Facility) was notified by an HHSC employee the facility was in Immediate Jeopardy (IJ) with an allegation of Supervision (F689) noncompliance. The surveyor provided an Immediate Jeopardy (IJ) Template notification via email that the Regulatory Services has determined that Immediate action is required to ensure residents are safe and provided correct supervision. Action: R1 was immediately assessed on 5/10/24, currently resides in the secure unit, elopement assessment reflects high risk and BIMs was completed on 5/10/24. 2. On 5/10/24 Maintenance checked all facility alarms for proper functioning, all alarms working at this time. 3. Residents that reside outside in the general population not the secure unit with diagnosis of Dementia were immediately assessed to make sure they were not an elopement risk and Elopement assessment completion. One was identified as being a potential for elopement, ADON immediately called physician and RP for consent to move to secure unit for safety and supervision. 4. On 5-10-24 the Administrator / or designee immediately in-serviced staff on Elopement policy those staff that did not attend in person or via phone for in-service will be in-service before the start of the next assigned shift. 5. On 5/10/24 Administrator in-service staff on door alarms in the secure unit and non-secure unit to make sure the staff know how to identify if they are properly working and the sound of the alarm when someone opens the door and attempts to exit, main front door, times were revised when they are locked and unlocked for safety. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

6. When the receptionist goes on break or leaves the front check another team member will sit and monitor the entrance/ exit during business hours. After hours, the front doors are locked through a maglock system. All residents will be identified using the Electronic Health Record (EHR) face sheets that include a photo, it will be updated by activities staff. Visitors will be requested to sign in and out for staff to verify and monitor who comes in and out of the facility.

7. On 5/10/24 Social services designee and admission nurses were in-service by Administrator on completing BIMS once a new resident admits to the facility.

Observations, interviews, and record reviews (5/11/2024-5/12/2024) included:

Observation on 05/11/2024 at 9:00 AM revelaed no residents were seen outside of the facility or in the parking lot, no residents were seen in the back of the facility or in the bridge area between the two building, and the front door was locked and the Receptionist were seen behind desk. Further observation revealed the Receptionist opened the door, and one resident was seen in the dining room, listening to music.

Observation on 05/12/2024 at 9:30 AM revealed no residents were seen outside. Futher observation around the facility outside did not reveal any resident outside without supervision.

Interview with the Administrator on 05/12/2024 at 9:45 AM, the Administrator stated all the doors were alarm and the staff were doing the rounds every shift to check there alarms were working. The Administrator stated, all BIMS have been audited as well as elopement risk and one resident who was previously in the locked unit was moved back in the locked unit as a preventive measure and the family agreed. Everybody who has been on shift since the elopement has been in-serviced Some were in-serviced by phone. Some they are still trying to get in the facility or reach by phone to in-serviced them.

Record review of Resident #1's electronic medical record revealed a Brief Interview for Mental Status (BIMS) was commpleted with the resident's family member on 5/10/2024 and the score was 1, which indicated severe cognitive impairment, with inattention fluctuating. Further review revealed an elopement risk assessment was completed on 05/07/2024 with a score of 12, which indicated high risk for elopement. Resident located in 300 hall which is the locked unit.

Record review of the facility's alarm door log revealed:

- 5/10/24 at 3:50 PM Maintenance Director checked a total of 8 doors on North unit that require alarms. All 8 doors were armed and working status

- 5/10/24 at 4:20PM Maintenance director checked 9 doors in south building with alarms and 2 outside gate with Maglocks and all alarms were working. Both gates were armed and locked. Rounds have been made since then q shift and at night to insure alarms are on. Per Administrator she is planning to change all the exiting alarms to alarms with keys. The keys will stay on the nurses key ring. That is for all doors that should not be used as exit. Everybody would then have to always exit by the front.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with with DA P on 05/12/2024 at 1:30 PM, DA P stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. DA P was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. DA P stated all of the at risk residents were in the locked unit. DA P revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Interview with with DA Q on 05/12/2024 at 1:32 PM, DA Q stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. DA Q was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. DA Q stated all of the at risk residents were in the locked unit. DA Q revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Interview with with PHT R on 05/12/2024 at 1:35 PM, PHT R stated he received in-service training by phone on 05/11/2024 which was regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. PHT R was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. PHT R stated all of the at risk residents were in the locked unit. PHT R revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Interview with with LVN K on 05/12/2024 at 1:40 PM, LVN K stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. LVN K was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. LVN K stated all of the at risk residents were in the locked unit. LVN K revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. LVN K further stated they had received in-service training for new admissions BIMS as well as elopement and alarms. Interview with with CNA S on 05/12/2024 at 1:50 PM, CNA S stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. CNA S was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. CNA S stated all of the at risk residents were in the locked unit. CNA S revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with with DA T on 05/12/2024 at 1:55 PM, DA T stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. DA T was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. DA T stated all of the at risk residents were in the locked unit. DA T revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Record review of the in-services log for BIMS assessed at admission 100 revealed all residents were assessed. Interview with with CNA U on 05/12/2024 at 2:02 PM, CNA U stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. CNA U was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. CNA U stated all of the at risk residents were in the locked unit. CNA U revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Interview with with CNA V on 05/12/2024 at 2:08 PM, CNA V stated she received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. CNA V was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. CNA V stated all of the at risk residents were in the locked unit. CNA V revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were going on pass or appointment. Interview with with HC W on 05/12/2024 at 2:14 PM, HC W stated he received in-service training regarding elopement procedures, including elopement prevention and what to do if somebody elopes, and door alarms, including checking the door alarms and answering them. HC W was asked about any resident, not in the locked unit, they may suspect to be at risk for elopement or exit seeking and no resident was named. HC W stated all of the at risk residents were in the locked unit. HC W revealed they knew to report to their nurse about any resident trying to exit the building, and they knew the residents had to sign in and out if they were goi [TRUNCATED]