STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675617	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Pass Nursing and Rehabilitation	2550 Zacatecas Dr Eagle Pass, TX 78852

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for 1 of 9 residents (Resident #1) reviewed for accidents and supervision , The facility failed to supervise Resident #1 who eloped from the facility on 09/07/24 through an unlocked door and sustained a fall with no injury in the course of the elopement. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/24/25. The non-compliance began on 09/07/24 and ended on 09/09/24. The facility had corrected the non-compliance before the survey began on 04/23/25. This deficient practice could place residents including Resident #1, who were elopement risks, at-risk of harm, serious injury, or death. The findings included: Record review of the face sheet for Resident #1 dated 4/23/25 revealed the 85- year- old male resident was admitted to the facility on [DATE] with the following diagnoses: unspecified dementia (a condition of cognitive impairment that can have occur for various reasons), anxiety disorder (a condition in which there are strong feelings of worry or fear), and unspecified convulsions (a condition in which a person has seizures where the specific cause is not identified). Record review of Resident #1's Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 6, which indicated the resident was severely cognitively impaired. Further review of the MDS indicated the resident exhibited a significant risk of wandering behavior. Record review of the Initial care plan for Resident #1 initiated on 6/3/24 revealed the resident had a risk of elopement potential. The interventions included identifying the pattern of wandering and distracting the resident from wandering with pleasant diversions and structured activities. Further review revealed the resident's care plan was changed on 9/7/24 to include the resident's elopement on 9/7/24. Record review of wandering assessment for Resident #1 dated 8/27/24 noted the resident had a history of wandering and was a risk for wandering behavior to continue. The wandering assessment was revised on 9/7/24 to include the elopement incident. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the physician order summary for Resident #1 dated 9/6/24 revealed the resident had an order for 30 minute monitoring dated 6/2/24 and an order for psychiatric evaluation dated 6/4/24. Record review of the chart progress notes for Resident #1 from 09/7/24 to 9/20/24 revealed the resident was under continuous 30 minute monitoring by nursing staff since return to the facility from the elopement with the plan for the 30 minute monitoring to be continued. Resident #1 was discharged on 9/21/24 to another nursing facility which had a secured unit. Observation from 04/23/25 to 04/25/25 between the hours of 8:00 a.m. and 1:00 p.m., of all the resident corridor hallways revealed the door alarms were in working order. During an interview with the Administrator and the Assistant Director of Nurses (ADON) on 4/23/25 at 10:30 am regarding the elopement incident., the ADON stated Resident #1 had eloped from the facility on 9/7/24 while waiting in the dining room for breakfast to be served. The ADON stated C.N.A-B had taken Resident #1 to the dining room at 7:15am and went to retrieve other residents to bring them to the dining room. C.N.A.-B found Resident #1's wheelchair unoccupied when she returned to the dining room. C.N.A-B immediately notified the Charge Nurse, and a Code Orange Elopement protocol was begun at 7:20 am. Resident #1 was found by C.N.A-C and C.N.A-D, to be lying on the ground outside the facility and outside the dining room door. Resident #1 was assessed by RN-A and found to have no signs of injury. Resident #1 had stated he was not in any pain. Resident #1 was brought back inside of the facility and it was determined the dining room door in which the resident had exited was unlocked. Resident #1 was transported to the local hospital at 7:58 am for further evaluation. It was determined in the hospital emergency room that Resident #1 had no signs of injury. Resident #1 was returned back to the facility at 11:15 am. The Administrator stated each of the facility's exit doors prior to the incident on 9/7/24 had been checked once a day for door lock/alarm viability. The Administrator stated the facility was unable to determine the staff member who unlocked the dining room door. The Administrator stated since the incident, each of the facility door locks were checked 3 times a day during each 8 hour shift for door lock/alarm viability. During an observation with the Maintenance Director on 4/23/25 from 11:30 am until 11:45 am all exit doors in the facility were checked for door lock/alarm viability. The Maintenance Director stated all of the facility exit doors were checked during every 8 hour shift for each 24 hour time frame for door lock/alarm viability. During an interview with the ADON and HR Director on 4/23/25 at 12:35 pm, the ADON and HR Director stated all of the active staff working in the facility at the time of the incident on 9/7/24 were in-serviced on resident elopement protocol. They stated all of the facility's current active staff had been in-serviced on elopement protocol. During an interview with C.N.A.-C on 4/23/25 at 1:45 pm she stated Resident #1 had been found on the ground next to the dining room door (outside of the facility) on 9/7/24 at 7:36 am. She stated she did not believe that Resident #1 could have walked more than 10-15 feet while outside the facility before he fell on the ground besides the dining room door. C.N.A.-C stated she had received the facility in-service conducted from 9/7/24 to 9/9/24 on elopement which included monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility and interventions to take during an elopement drill. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with C.N.A.-D on 4/23/25 at 1:50 pm she stated that Resident #1 had been found on the ground next to the dining room door(outside the facility) on 9/7/24 at 7:36 am. She stated she did not believe that Resident #1 could have walked more than 10-15 feet while outside the facility before he fell on the ground beside the dining room door. C.N.A.-D stated she had received the facility in-service conducted from 9/7/24 to 9/9/24 on elopement which included monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility and interventions to take during an elopement drill. During an interview with RN-A on 4/23/25 at 1:55 pm he stated Resident #1 had been found on the ground next to the dining room door(outside the facility) on 9/7/24 at 7:36 am. RN-A stated Resident #1 was assessed and found to have no signs of injury. RN-A stated Resident #1 voiced no pain at the time of the assessment. RN-A stated he had received the facility in-service conducted from 9/7/24 to 9/9/24 on elopement which included monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility and interventions to take during an elopement drill. During an interview on 4/23/25 from 1:40 pm to 2:30 pm with 6 CNAs (E, F, J, M, N, and P), 5 LVNs (H, I, K, O, and Q), 1 RN (G) and 1 MA (L) who confirmed they had received the facility in-service on elopement conducted from 9/7/24 to 9/9/24 and included: monitoring residents for exit seeking behaviors such as checking exits, pushing on doors, and verbalizing wanting to leave the facility. Record review of active employee roster dated 9/7/24 noted all employees had received elopement protocol training. Record review of the active employee roster dated 4/23/25 noted all active employees had received elopement protocol training. Record review of the facility's alarm monitoring form from 9/7/24 thru 4/23/25 revealed all exit doors in the facility were checked for door lock/alarm functionality every 8 hours during a 24 hour time frame with no concerns noted. Record review of the facility's policy titled, Elopement Response, dated 10/27/10 in the Nursing Policy and Procedure Manual, revealed for the post return resident evaluation and care the facility will evaluate it's elopement prevention program and all residents will be re-assessed for elopement risk.