STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675918	A. Building B. Wing	09/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracy Woods Nursing Center	12021 Metric Blvd Austin, TX 78758

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 1 resident (Resident #1) reviewed for accidents, hazards, and supervision. The facility failed to put effective measures in place to prevent Resident #1 from eloping. Resident #1 was found 26 hours after he eloped. The facility did not have a plan in place for monitoring the windows to ensure resident supervision/monitoring was in place to prevent Resident #1's elopement. On 09/12/2025 at 5:05 p.m., an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/13/2025 at 3:00 p.m., the facility remained out of compliance at a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of experiencing accidents, injuries, and/or death. The findings included:Record review of Resident #1's face sheet dated 09/12/2025 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1's diagnosis included cerebral infraction (long term effects of a stroke), left middle cerebral artery mixed receptive-expressive language disorder (a language disorder in which both the receptive and expressive areas of communication may be affected in any degree from mild to severe), heart failure, cardiomyopathies (progressive heart disease), aphasia following cerebral infraction (unable to comprehend after a stroke), cannabis intoxication with delirium (a disturbance in attention and awareness along with other cognitive impairments), and methamphetamine abuse (a synthetic stimulant to increase alertness and energy). Record review of Resident #1's entry MDS dated [DATE] revealed Resident #1's BIMS was not completed. During interviews with staff on 09/12/2025 from 11:00a.m. to 3:00p.m., (LVN A, LVN B, CNA C and RN D) and record review of progress notes revealed Resident #1 was cognitively impaired. Resident #1's care plan dated 09/10/2025 revealed, Resident #1 was confused. The baseline care plan also stated that the resident had behavior concerns- confusion. The care plan revealed Resident #1 was ambulatory. Record review of Resident #1's elopement assessment revealed the resident was not marked as having cognitive impairment. The elopement risk also did not indicate Resident #1 was an elopement risk. During an interview with Resident #1's FM #1 on 09/12/2025 at 9:34a.m., revealed the resident was admitted to the facility on [DATE] at around 6pm. She said the facility called her on 09/11/2025 at around 8:30am and said he had left the facility. She said that Resident #1 did not even know who his FM was when asked. She said the facility was trying to get the family to sign a document that stated they were not liable, but she said she would not sign the documents. She said Resident #1 had never been in a facility before. She said the facility would give her different stories as to what happened. During an interview with Resident #1's FM #2 on 09/12/2025 at 9:59a.m., revealed the facility called and told her that Resident #1 was gone. She said the facility said they checked on Resident #1 at 6:30am and when they checked again at 8:30am he was not there. She said he had been homeless. She said when they went to see Resident #1 right before he was discharged from the hospital, he did not know who they were. She said that the police had not come to talk to the FM. She said the facility had called the police when Resident #1 eloped from the facility. During an interview with LVN A on 09/12/2025 at 11:15a.m., revealed she had gone to do her rounds around 6:00am and Resident #1 was in the bed. She said she went back to see if Resident #1 got his breakfast around 8:00am and he was not in the room. She said she checked to see if Resident #1 was in the bathroom, and he was not. She said she then called the ADM. She said she did a head count and staff searched for Resident #1. She said that when she was searching for Resident #1, she noticed the window up and the screen was off. She said with Resident #1 being confused he was considered an elopement risk. She said she did not know why the other nurse did not mark Resident #1 on the elopement assessment as cognitively impaired. She also said she was trained on completing the elopement assessment in the computer in July of 2025. During an interview with LVN B on 09/12/2025 at 11:26a.m., revealed she admitted Resident #1. She said when he came in, he was friendly. She said as soon as EMS dropped him off, he was walking around the facility. She also said that he was not trying to exit the building and did not say he wanted to leave. She said he looked normal but when you had a conversation with him, he could not remember stuff. She said he was confused. She said he could not tell her what day it was, who the president was, and what month it was. She said he did not appear anxious when he was walking around the facility. She said she did not consider him an elopement risk. She also said he did not appear to be one that would elope. She said with Resident