STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676271	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Onion Creek Nursing and Rehabilitation Center	1700 Onion Creek Pkwy Austin, TX 78748

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** 42949 Based on interview and record review, the facility failed to ensure all alleged violations involving abuse or neglect were reported immediately or no later than 24 hours for one (Resident #1) of three residents reviewed for abuse and neglect. The facility failed to report to the State Agency an incident when Resident #1 left the facility without nursing staff being aware on 02/16/25. This failure could place residents at risk of abuse or and neglect. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including psychotic disorder with delusions, generalized anxiety disorder, dementia, unsteadiness on feet, and difficulty in walking. She was not her own RP. Review of Resident #1's quarterly MDS assessment, dated 11/08/24, reflected a BIMS score of 10, indicating a moderate cognitive impairment. Section E (Behavior) reflected she had not exhibited behaviors of wandering. Section GG (Functional Abilities) reflected she utilized a walker for ambulation. Review of Resident #1's quarterly care plan, dated 01/15/24, reflected she was at risk for impaired cognitive function/dementia or impaired thought process with an intervention of needing supervision/assistance with all decision making. There was no focus area related to wandering or elopement. Review of Resident #1's quarterly Elopement/Wandering Evaluation, dated 01/10/23, reflected a score of 15, indicating she was a high-risk for elopement. Review of Resident #1's progress note, dated 02/16/25 at 5:24 PM and documented by LVN C, reflected the following: [Resident #1] signed herself out 2-16-25 at 11:40 am went to the (store) in (town), [Resident #1] returned around 14:00 (2:00 PM) DON aware. After returning back to facility [Resident #1] went to her room. (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: 676271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
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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	Review of Resident #1's progress note, dated 02/16/25 at 5:49 PM and documented by the DON, reflected the following: [Resident #1] is cognitively intact (BIMS 15) and able to make decisions, although she has had a change in condition and is not making safe decisions and voicing desire to leave and attempting without a safe plan in place . Review of the Out on Pass binder at the desk in the front lobby, on 02/18/25, reflected Resident #1 signed out on 02/16/25 at 11:40 AM but there was no returned time documented. During a telephone interview on 02/17/25 at 3:48 PM, CNA D stated Resident #1 eloped from the facility on 02/16/25. She stated she was working that day but on another hall. She stated she (Resident #1) left sometime in the morning and was brought back to the facility around 2:00 PM. She stated no one knew how long she had been missing. She stated she did not see her in the dining room at lunch, but that was not unusual because she often ate her meals in her room. She stated the facility received a call from someone at another facility notifying them of where she was located. She stated the ADM went and picked her up and brought her back. She stated the ADM and DON talked to Resident #1's nurse, LVN C, and told her it was not an elopement since she signed herself out. She stated Resident #1 was in their high-elopement binder at the nurses' station and Resident #1 did not have the cognitive ability to sign herself out. She stated she was currently on a 1:1 due to the elopement. She stated she believed the ADM should have reported this incident to the State. During a telephone interview on 02/18/25 at 10:07 AM, LVN C stated she was working Resident #1's hall on 02/16/25. She stated no one knew Resident #1 had left the facility until LVN G received a phone call from the van driver from a facility close by and informed him she was seen at the grocery store in a town approximately five miles way. She stated everyone knew she was not allowed to sign out or leave the facility without someone knowing and going with her. She stated she attempted to leave the facility daily and constantly had to be re-directed. She stated everyone was aware she was not supposed to leave the facility. She stated she immediately called the DON to notify her of Resident #1's location and she and the ADM brought her back to the facility. She stated the DON told her it was not considered an elopement because she signed herself out, she was aware what she was doing, and her mental status was fine. She stated she did sign out at the front desk but as a nurse, she considered it an elopement because no one knew she was gone or where she was. She stated she could have gotten seriously hurt. During an interview on 02/18/25 at 10:38 AM, CNA H stated he worked Resident #1's hall on 02/16/25. He stated it was not his normal hall, so he was not that familiar with her but did know she was ambulatory and liked to sit in the lobby by the Receptionist's desk. He stated he did remember seeing her that day but did not remember what time. He stated he heard a rumor she was missing but he did not see anything. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER: Onion Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Onion Creek Pkwy Austin, TX 78748	

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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	During a telephone interview on 02/18/25 at 11:25 AM, Resident #1's FM I stated she should not have been able to leave the facility on her own. He stated he was very upset she was able to walk out the front door. He stated when he took her out on pass, he had to sign out at two different locations and then get the Receptionist to put the code in to unlock the door, How did she get past all that? He stated he understood she could physically sign herself out, but she had dementia, and it was not safe at all. He stated if she walked out the door and forgot where she was at, then what? He stated she could have gotten ran over or gotten left for dead. He stated he believed the weekend Receptionist (REC J) was a new hire and probably had not been thoroughly trained. He stated the Administrator and DON were aware she had a history of eloping when she was admitted . During an interview on 02/18/25 at 2:32 PM, the DON stated it was preferred that when a resident wanted to leave, they would sign out and notify their nurse. She stated sometimes residents would forget to notify their nurse. The ADM stated there was a sign out book at the nurses' station and the Receptionist's desk where the residents were supposed to sign out. She stated for a resident to go out on pass alone, it would depend on their cognitive level and their BIMS score. The ADM stated the BIMS score would need to be high - 13, 14, or 15. She stated if a resident had a BIMS score of 10, it would depend and they would need to talk to their provider about it. The ADM stated staff knew which residents were a high-elopement risk by their elopement binders located at the nurses' station and Receptionist's desk. The ADM stated on 02/16/25, REC J told her Resident #1 came to the desk and told her she was going out and signed out in the binder. She stated REC J told her she did not leave, but just sat in the lobby. She stated REC J went to lunch and when she came back Resident #1 was gone. She stated Resident #1 left at some point and was not sure how she left without the code to the door. She stated at that time she was able to be out independently at that time because of her cognitive status and high BIMS score. She stated she was able to answer all of their questions, such as where she had gone and what she had been doing. The ADM stated they did not consider it an elopement because when they found out she was not in the building, they went to the book and saw that she had signed out and, in that moment, they knew where she was. She stated when they got to her location, she was safe and knew everything she was doing. The ADM stated she did not report the incident to the State because they did not consider it an elopement because she had signed out. On 02/18/25 at 10:20 AM and 1:14 PM, attempts were made to interview LVN G. A returned call was not received prior to exiting. On 02/18/25 at 10:24 AM and 12:35 PM, attempts were made to interview REC J. A returned call was not received prior to exiting. Review of the facility's undated Abuse and Neglect Policy reflected nothing related to reporting to the State after a resident elopement. Review of HHSC's PL 2024-14, dated August 29,204, reflected emergency situations that pose a threat to resident health and safety should be reported to HHSC immediately, but not later than 24 hours after the incident occurs or is suspected.

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NAME OF PROVIDER OR SUPPLIER Onion Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 Onion Creek Pkwy Austin, TX 78748	

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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	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** 42949 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not leave the facility with nursing staff being aware as she was found approximately 2.5 hours later and approximately 4.2 miles away (at a store off a major highway - 65 MPH) after being contacted by an outside party 02/16/25. The temperature was approximately 58 degrees. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 02/18/25 at 2:16 PM and an IJ template was given. While the IJ was removed on 02/19/25 at 4:42 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for unsafe elopements, falls, injuries, dehydration, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including psychotic disorder with delusions, generalized anxiety disorder, dementia, unsteadiness on feet, and difficulty in walking. She was not her own RP. Review of Resident #1's quarterly MDS assessment, dated 11/08/24, reflected a BIMS score of 10, indicating a moderate cognitive impairment. Section E (Behavior) reflected she had not exhibited behaviors of wandering. Section GG (Functional Abilities) reflected she utilized a walker for ambulation. Review of Resident #1's quarterly care plan, dated 01/15/25, reflected she was at risk for impaired cognitive function/dementia or impaired thought process with an intervention of needing supervision/assistance with all decision making. There was no focus area related to wandering or elopement. Review of Resident #1's quarterly Elopement/Wandering Evaluation, dated 01/10/23, reflected a score of 15, indicating she was a high-risk for elopement. Review of Resident #1's progress note, dated 01/14/25 at 1:08 AM and documented by LVN F, reflected the following: [Resident #1] found rummaging through front desk drawers. CN was advised that [Resident#1] has attempted to exit the facility prior to today's date . Review of Resident #1's MD progress note, dated 01/21/25, reflected the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Discussed with [Resident #1] again upon request from her to talk about her taking the bus, discussed with director of nursing and administrator, that and we all agree that [Resident #1] is safe to go, as long as there is a chaperone with her . Review of Resident #1's progress note, dated 01/30/25 at 5:28 PM and documented by LVN A, reflected the following: [Resident #1] is asking all during shift if can go and take the bus to pick up income taxes. Writer redirected [Resident #1] to speak with social worker or administrator for the ok to leave facility. [Resident #1] is not allowed to leave facility without supervision from stass [sic] or family. Review of Resident #1's progress notes, dated 02/03/25 at 1:50 PM and documented by LVN B, reflected the following: Will continue to monitor for elopement, plan of care ongoing. Review of Resident #1's NP progress note, dated 02/03/25, reflected the following: Otherwise, nursing reporting [Resident #1] has been trying to leave facility . Upon discussion with nursing staff, [Resident #1] often with these behaviors intermittently . Although, [Resident #1] tells me she talked to (name) recently and is discharging tomorrow to a different facility. No discharge plans have been made. Is a wander risk. Alerted staff and DON regarding [Resident #1]'s above statement. (Psychiatric team) is following. Will have (Psychiatric team) follow up. . Mood stable today, thought with intermittent agitation and wandering behaviors . Review of Resident #1's progress notes, dated 02/16/25 at 5:24 PM and documented by LVN C, reflected the following: [Resident #1] signed herself out 2-16-25 at 11:40 am went to the (store) in (town), [Resident #1] returned around 14:00 (2:00 PM) DON aware. After returning back to facility [Resident #1] went to her room. Review of Resident #1's progress note, dated 02/16/25 at 5:49 PM and documented by the DON, reflected the following: [Resident #1] is cognitively intact (BIMS 15) and able to make decisions, although she has had a change in condition and is not making safe decisions and voicing desire to leave and attempting without a safe plan in place . Review of the Out on Pass binder at the desk in the front lobby, on 02/18/25, reflected Resident #1 signed out on 02/16/25 at 11:40 AM but there was no returned time documented. Observations made on 02/18/25 at 9:02 AM revealed an elopement binder with residents that were a high risk located at the Receptionist's desk and each nurses' station. The binders contained Resident #1's information. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During a telephone interview on 02/17/25 at 3:48 PM, CNA D stated Resident #1 eloped from the facility on 02/16/25. She stated she was working that day but on another hall. She stated she (Resident #1) left sometime in the morning and was brought back to the facility around 2:00 PM. She stated no one knew how long she had been missing. She stated she did not see her in the dining room at lunch, but that was not unusual because she often ate her meals in her room. She stated the facility received a call from someone at another facility notifying them of where she was located. She stated the ADM went and picked her up and brought her back. She stated the ADM and DON talked to Resident #1's nurse, LVN C, and told her it was not an elopement since she signed herself out. She stated Resident #1 was in their high-elopement binder at the nurses' station and Resident #1 did not have the cognitive ability to sign herself out. She stated she was currently on a 1:1 due to the elopement.

During an observation and interview on 02/18/25 at 8:59 AM revealed CNA E sitting in a chair next to Resident #1's bed. She stated Resident #1 was on 1:1 and she was to ensure she stayed with her. She stated she was not sure why she was on a 1:1 but thought it had to do something with an elopement. Resident #1 stated it was because of her shopping trip. She then started crying and talking about the social worker, not getting her money, and missing her family member. She was hard to redirect.

During a telephone interview on 02/18/25 at 10:07 AM, LVN C stated she was working Resident #1's hall on 02/16/25. She stated no one knew Resident #1 had left the facility until LVN G received a phone call from the van driver from a facility close by and informed him she was seen at the grocery store in a town approximately five miles way. She stated everyone knew she was not allowed to sign out or leave the facility without someone knowing and going with her. She stated she attempted to leave the facility daily and constantly had to be re-directed. She stated everyone was aware she was not supposed to leave the facility. She stated she immediately called the DON to notify her of Resident #1's location and she and the ADM brought her back to the facility. She stated the DON told her it was not considered an elopement because she signed herself out, she was aware what she was doing, and her mental status was fine. She stated she did sign out at the front desk but as a nurse, she considered it an elopement because no one knew she was gone or where she was. She stated she could have gotten seriously hurt.

During an interview on 02/18/25 at 10:38 AM, CNA H stated he worked Resident #1's hall on 02/16/25. He stated it was not his normal hall, so he was not that familiar with her but did know she was ambulatory and liked to sit in the lobby by the Receptionist's desk. He stated he did remember seeing her that day but did not remember what time. He stated he heard a rumor she was missing but he did not see anything.

During a telephone interview on 02/18/25 at 11:25 AM, Resident #1's FM I stated she should not have been able to leave the facility on her own. He stated he was very upset she was able to walk out the front door. He stated when he took her out on pass, he had to sign out at two different locations and then get the Receptionist to put the code in to unlock the door, How did she get past all that? He stated he understood she could physically sign herself out, but she had dementia, and it was not safe at all. He stated if she walked out the door and forgot where she was at, then what? He stated she could have gotten ran over or gotten left for dead. He stated he believed the weekend Receptionist (REC J) was a new hire and probably had not been thoroughly trained. He stated the Administrator and DON were aware she had a history of eloping when she was admitted .

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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	During a telephone interview on 02/18/25 at 1:13 PM, Resident #1's NP stated it was not safe for her to leave the facility on her own. She stated her psychiatric competency was more complex than most. She stated something would happen, she would get confused, or get lost. She stated if she had signed out, it would still be considered an elopement because the staff did not know she left or her whereabouts. During a telephone interview on 02/18/25 at 1:57 PM, Resident #1's MD stated she had been asking to leave the facility for a long time. He stated they had been trying to do the right thing for her and her safety but also be respectful of her wishes and rights. He stated she was over-all pretty with it in terms of her alertness and orientation. He stated she historically needed to be redirected from the front door. He stated ideally, she would need a chaperone to go out on pass. He stated there was no real reason why she could not go out and it would be against her rights and will. He stated he did expect for there to be a process in place when a resident signed out to leave the facility, but he could not remember what theirs was. He stated generally, staff should be aware when a resident was leaving the facility. During an interview on 02/18/25 at 2:32 PM, the DON stated it was preferred that when a resident wanted to leave, they would sign out and notify their nurse. She stated sometimes residents would forget to notify their nurse. The ADM stated there was a sign out book at the nurses' station and the Receptionist's desk where the residents were supposed to sign out. She stated for a resident to go out on pass alone, it would depend on their cognitive level and their BIMS score. The ADM stated the BIMS score would need to be high - 13, 14, or 15. She stated if a resident had a BIMS score of 10, it would depend and they would need to talk to their provider about it. The ADM stated staff knew which residents were a high-elopement risk by their elopement binders located at the nurses' station and Receptionist's desk. The ADM stated on 02/16/25, REC J told her Resident #1 came to the desk and told her she was going out and signed out in the binder. She stated REC J told her she did not leave, but just sat in the lobby. She stated REC J went to lunch and when she came back Resident #1 was gone. She stated Resident #1 left at some point and was not sure how she left without the code to the door. She stated at that time she was able to be out independently at that time because of her cognitive status and high BIMS score. She stated she was able to answer all of their questions, such as where she had gone and what she had been doing. The ADM stated they did not consider it an elopement because when they found out she was not in the building, they went to the book and saw that she had signed out and, in that moment, they knew where she was. She stated when they got to her location, she was safe and knew everything she was doing. On 02/18/25 at 10:20 AM and 1:14 PM, attempts were made to interview LVN G. A returned call was not received prior to exiting. On 02/18/25 at 10:24 AM and 12:35 PM, attempts were made to interview REC J. A returned call was not received prior to exiting. Review of the facility's Elopement/Unsafe Wandering Policy, revised 12/2023, reflected the following: It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Definition: Elopement occurs when a resident leaves the facility premises or a safe area without the facility's knowledge, authorization (i.e. an order for discharge, appointment, or leave of absence) and/or any necessary supervision to do so. The ADM and DON were notified on 02/18/25 at 2:16 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 02/19/25 at 2:39 PM: Action: 100% all staff in service on communication regarding out on pass with nursing approval and elopement process. PRN staff in serviced, we do not utilize agency staff and new staff will be in serviced upon hire. Resident was put on 1:1, psychological evaluation completed by Psychology Services (pending report), neurocognitive testing initiated due to change of condition conducted by Psychological Services (pending report), 100% audit for high-risk elopement residents completed. There were no other residents identified that may display this behavior. Previous protocol: Charge nurse is informed, resident signs out on at reception or nurse's station. Current protocol: Charge nurse to be notified of request and confirms with IDT that resident is appropriate for out on pass independently, Charge nurse completes sign out sheet with resident, informs receptionist if resident is appropriate for out on pass. RP, Resident and Provider to be notified by DON or designee with IDT determination. DON or designee responsible for ongoing compliance. Sign out book has been reviewed as of 2/19/25 and will be audited ongoing in QAPI x90 days to ensure ongoing compliance. Audit on high-risk elopement resident completed by DON and Clinical Resource on 2/18/25. Conducting 100% all staff in service on Elopements. Start Date: 02/18/2025 Completion Date: 02/19/2025 Responsible: Executive Director, Director of Nursing Services or designee. Action: Medical director notified of IJ Start Date: 02/18/2025 Completion Date: 02/18/2025 Responsible: Director of Nursing Services (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: An Ad hoc QA meeting will be completed. Attendees will include ED, DON, ADON, Clinical Resource, and Medical Director. Meeting will include the Plan of Removal and interventions. Start Date: 02/18/2025 Completion Date: 02/18/2025 Responsible: ED/DON Action: Train the trainer in-service given to ED and DON on communication for out on pass Start Date: 02/18/2025 Completion Date: 02/18/2025 Responsible: Clinical Resource Action: ED or Designee will verify staff knowledge on communication for out on pass with 10 staff weekly using the abuse and neglect knowledge checks. This will be completed weekly following the initial training and knowledge checks Knowledge check will be completed by quizzes and in services. This will continue for 90 days then ongoing for all new hires. Start Date: 02/18/2025 Completion Date: 05/18/2025 Responsible: ED/Designee Action: Summary of IJ and corrective action to be reviewed by QAPI Committee weekly x 4 weeks beginning 02/18/25 or until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. Start Date: 02/18/2025 Completion Date: 05/18/2025 Responsible: ED/DON The Surveyor monitored the POR on 02/19/25 as followed: During an interview on 02/19/25 at 2:45 PM, the ADM stated more than 90% of their staff had been in-serviced on elopement and residents leaving out on pass. She stated no one will work until they get in-serviced. She stated Resident #1 had psychiatric and neurocognitive evaluations conducted the day prior, 02/18/25, and the reports were still pending. (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 - Few	During interviews on 02/19/25 from 2:58 PM - 4:21 PM, four LVNs, two CNAs, one MA , and REC K (weekday receptionist) from different shifts all stated they were in-serviced before their shifts on elopement and the process for residents signing out on pass. All were able to describe what the elopement binders were and where they were located. All staff knew to redirect residents to their nurse if voicing a desire to go out on pass. Each staff member was able to define elopement as a resident leaving the facility premises without the staff being aware. The nurses stated they would assess their cognitive status and orientation and would contact the DON for further approval. The nurses stated the log had to be filled out completely whether the resident was leaving with staff and/or family or if leaving independently - name, date, time, location, phone number, and estimated time of return. The nurses stated any time a resident signed out, they would then accompany them to the receptionist area, have them sign out again, and then give the Receptionist the okay to unlock the door. All staff were able to give possible signs and symptoms of residents seeking elopement - pacing to exit doors, voicing wanting to leave, agitation, or actively exit-seeking. All staff stated residents should be rounded on at least every two hours and if they were unable to locate them, the nurse should be notified immediately. Observation on 02/19/25 at 2:42 PM revealed Resident #1 ambulating in the lobby with a CNA closely behind her providing 1:1 supervision. Review of the facility's Ad Hoc QAPI agenda, dated 02/18/25, reflected the ADM, DON, AIT, DOR, ADON, MD, SW, MDSC, and other corporate officials were in attendance. Review of in-services entitled Communication Regarding Out on Pass, dated from 02/18/25 - 02/19/25, reflected nursing staff from all shifts were in-serviced. Review of Out on Pass quizzes, dated from 02/18/25 - 02/19/25, reflected nursing staff from all shifts completed the following quiz: 1. If a resident wants to go out on pass, where do they need to be directed for clearance? 2. Who can give the ok for a resident to go out on pass independently? 3. Where is the sign out binder located? 4. How does the receptionist know if a resident can go out on pass? Review of in-services entitled Elopement, dated from 02/18/25 - 02/19/25, reflected nursing staff from all shifts were in-serviced on their elopement policy. Review of Elopement Inservice quizzes, dated from 02/18/25 - 02/19/25, reflected nursing staff from all shifts completed the following quiz: Location of elopement binder What to do if possible elopement 3 patients that are located in elopement binder (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER: Onion Creek Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1700 Onion Creek Pkwy Austin, TX 78748	

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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	Review of the facility's elopement binder, on 02/19/25, reflected fifteen residents that were deemed a high risk. Three residents' EMR's were reviewed to reflect they were a high-risk of elopement. Review of Resident #1's progress note, dated 02/19/25 at 1:22 PM and documented by the SW, reflected the following: Called [FM I] for quarterly care plan meeting. Review of Psychological Evaluation, dated 02/18/25, reflected Resident #1 had a psychological evaluation conducted. The ADM and DON were notified the IJ was removed on 02/19/25 at 4:42 PM. However, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.