STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676308	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Rehabilitation and Care Center	4100 College Park Dr Round Rock, TX 78665

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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** 42600 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not leave the facility without supervision and/or staff knowledge as she was found in the street in front of the facility by visitors of the facility on 02/23/2025. An Immediate Jeopardy (IJ) was identified on 03/17/2025. The IJ template was provided to the facility on [DATE] at 5:04 PM. While the IJ was removed on 03/18/2025 the facility remained out of compliance at a scope of isolated and a severity level of not actual harm because all staff had not been trained on elopement. This failure could place residents at risk of unsafe elopements, falls, injuries, hospitalization and/or death. Findings included: Review of Resident #1 face sheet reflected [AGE] year-old women admitted on [DATE] and discharged on [DATE] with diagnoses of vascular dementia (a type of dementia caused by impaired blood flow to the brain, often due to strokes or other conditions that damage blood vessels, leading to problems with memory, thinking, and behavior), altered mental status (a change in a person's level of consciousness, alertness, and cognitive function), psychotic disorder with delusions (mental health condition characterized by persistent and false beliefs that are not based on reality), and anxiety disorder (a group of mental health conditions characterized by excessive and persistent feat, worry, and nervousness that can interfere with daily life). Review of Resident #1 care plan dated 02/26/2025 reflected Resident #1 had behavioral symptoms and Resident #1 wandered throughout the facility and was at risk for elopement and entering into others personal space. Approached included resident will be identified to staff through the facility alert system as an elopement risk. Review of Resident #1 care plan date 02/11/2025 reflected Resident #1 was rarely understood due to confusion. Further review of care plan dated 02/11/2025 reflected Resident #1 had impaired cognition and approached included to redirect Resident #1 when entering unsafe areas. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1 social service assessment dated [DATE] reflected resident was cognitively impaired. Resident #1 exhibited wandering behaviors and was exit seeking. Review of Resident #1 admission elopement assessment dated [DATE] reflected Resident #1 was an elopement risk. Review of Resident #1 elopement assessment dated [DATE] reflected Resident #1 got out the door on 400 hall. Interventions included to keep Resident #1 in common area and keep an eye on her. Resident #1 continued to be an elopement risk indicated by proceed selection on assessment. Review of Resident #1 progress note dated 12/04/2024 reflected Resident #1 had increased behavior and was exit seeking at side door of hallway. Review of Resident #1 progress note dated 01/15/2025 reflected Resident #1 attempted to go through the front door twice after visit from family. Review of Resident #1 progress note dated 02/06/2025 reflected resident tried to open hallway exit door. Review of Resident #1 progress note dated 02/23/2025 reflected Resident #1 followed visitors out the front door at 11:30 AM. Observation on 03/17/2025 at 9:30 AM, revealed a sign posted at the front door with a door code for outgoing and incoming visitors. During an interview on 03/17/2025 at 12:12 PM, LVN A stated she was familiar with Resident #1. LVN A stated that Resident #1 was confused and she would get up and walk without her wheelchair and she was not easily redirectable. LVN A stated that Resident #1 was going to do what she (Resident #1) wanted to do. LVN A stated she attempted to provide Resident #1 with a task throughout the day to try and take Resident #1's mind off wanting to leave. LVN A stated on 02/06/2025 Resident #1 tried to exit through the hallway door but she did not exit the building. LVN A stated that Resident #1 admitted with exit seeking behaviors and they increased the last month she was at the facility. LVN A stated that Resident #1 was put on 15 minute checks daily and this started on 02/06/2025. LVN A stated normally the checks would go for three days but continued until Resident #1 discharged due to her behavior. LVN A stated that she escorts the resident who sign out to the front desk and stated when they get to the front desk they go through a second sign-out process. LVN A stated there is a resident out on pass binder for each nurses station. LVN A stated she also documented all leave information on the 24-hour report. LVN A stated that all staff were trained on this process. LVN stated there was a binder kept at the nurses station that had residents who were at risk for elopement. During an interview on 03/17/2025 at 12:33 PM, RN B stated that she escorts residents who sign out of the facility for the day to the front desk to be released. She stated that there is a second sign-out process at the front as well. RN B state she documented residents who sign-out of the facility in the 24-hour report. RN B stated residents are required to sign out in the resident out on pass binder. (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 03/17/2025 at 12:55 PM, CNA C stated that she was not sure if there was a list that she could look at for residents who were at risk of elopement. CNA C stated she would look for the resident if she could not find them. CNA C stated she was not sure what else she would do if there was an elopement. During an interview on 03/17/2025 at 12:57 PM, CNA D stated that she was familiar with Resident #1. CNA D stated that sometimes Resident #1 did not make sense when she was speaking. CNA D stated that Resident #1 tried to leave the facility a couple of times and towards the end of her stay she had a sitter with her. CNA D stated that staff were able to get Resident #1 before she left the building during her attempts. CNA D stated that she remembered she got in-serviced on elopement. CNA D stated there was a binder at the nurses station on residents who were an elopement risk. CNA D stated if there was a resident who was missing, she would first look at the elopement binder, look in the building such as in the bathroom and other residents' rooms, nurses station and halls. She stated she would then let the nurse know before she started to search. CNA D stated that if residents were to go out on pass the family has to go the nurses station and sign the resident out when the leave and when they get back. CNA D stated there was only one resident on her hall who was considered an elopement risk. During an interview on 03/17/2025 at 1:11, LVN E stated that she was working when Resident #1 got out the front door. LVN E stated that there was a CNA clocking out for lunch and she told LVN E she was needed at the front door. LVN E stated when she got to the front door Resident #1 was back inside the building and was trying to get out again. LVN E stated Resident #1 was very agitated. LVN E stated that she placed Resident #1 in the vestibule between the door to the lobby area and outside door to help calm her down. LVN E stated that she believed on of the visitors called the police and a police officer came to the facility. LVN E stated that after a few minutes LVN E forgot what was going on and went back inside the building. LVN E stated that she went around the facility and asked staff to keep an eye on Resident #1 and call LVN E if Resident #1 went for the door. LVN E stated Resident #1 had 15 minutes checks. LVN E stated that usually facilities have a binder with residents who are at risk for elopement but she has not seen one at the facility and was unsure where it was. LVN E stated that she did receive an in-service on elopement. LVN E stated that the procedure for residents who go out on pass was that family walked them out and ensured they were signed out in the book at the nurses station. LVN E stated that it was not documented anywhere else if a resident went out on pass and the family notified the receptionist. LVN E stated she did not notify the receptionist if a resident left on pass. During an interview on 03/17/2025 at 1:41 PM, Receptionist F stated that when residents were leaving the facility they checked out with her on a kiosk. Receptionist F stated that they also have to sign out with the nurse before leaving the facility. Receptionist F stated that the nurses usually contacted her and let her know ahead of time who was leaving the facility. Receptionist F stated that if she saw a resident leaving she would double check with the nurse that they signed out. (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 on 03/17/2025 at 2:30 PM, Receptionist G stated she worked at the facility on the weekends. Receptionist G stated that she was working when Resident #1 left the facility. Receptionist G stated that it was around 10:30 - 11:00 AM. Receptionist G stated that she was still getting to know the residents. Receptionist G stated that Resident #1 would wheel around the facility in her wheelchair. She stated that two couples came into the facility in the morning and when one couple was leaving, Resident #1 was behind them and left out the front door. Receptionist G stated that she assumed that it was Resident #1's family and that they checked out at the nurses station. She stated that one person from the couple came back in about five minutes later and stated that Resident #1 was in the middle of the road. Receptionist G stated that she went outside and attempted to reassure Resident #1 and stated that she needed to go back inside. Receptionist G stated that Resident #1 stated that she needed to go home. Receptionist G stated Resident #1 refused to go into the facility and stood up from her wheelchair in the middle of the road and started to wave down cars that passed. Receptionist G stated that a person stopped their car and Resident #1 pulled on their door handled and asked them to call 911. Receptionist G stated there were a lot of cars around. Receptionist G stated she did not recall getting trained on elopement prior to starting at the facility. Receptionist G stated that after the elopement the facility provided her a binder with all residents' pictures in it. She stated that she does not know if any list or any information where residents who were an elopement risk was located. Receptionist G stated she was not aware of any residents who were an elopement risk. Receptionist G stated that she was unsure if residents signed out of the facility unless she stopped them to ask or if she received a call from the family member ahead of time. Receptionist G stated that the nurses did not let her know ahead of time or before a resident signed out. Receptionist G stated she sometime called the nurse to ask but not every time. Reception G stated that she had not received an in-service to review an elopement binder. She stated she received a binder after the incident, but it was not reviewed with her and stated it contained all residents' pictures, names and room numbers. During an interview on 03/17/2025 at 3:26, the ADM stated that residents were supposed to sign out at the nurses station when they left the facility. The ADM stated the nurse was responsible for ensuring the resident had signed out. The ADM stated that the nurse does not typically let the receptionist know the resident was going out on pass because facility would not typically keep any residents at the facility that could not go out by themselves because they were not a locked facility. The ADM stated that the facility kept an elopement binder because there were residents who were confused. She stated they did not exit seek but they were confused. The ADM stated she was unable to say the level of confusion Resident #1 was prior to the elopement as she had started to deteriorate. The ADM stated that Receptionist G was educated on elopement and she was educated on the elopement binder and the policy and procedure. The ADM stated she [Receptionist G] did everything right. The ADM stated that Receptionist G just did not know the resident and the families. The ADM stated that BOM came in and educated Receptionist G on the day the elopement happened and believed it was documented. The ADM stated she was not sure it was documented on the elopement in-service. (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 on 03/17/2025 at 3:40 PM, the BOM stated that she completed an in-service with Receptionist G and Receptionist E and this included to check the elopement binder and stated that they were to check with every resident going on if they checked out before the left the facility. The BOM stated Receptionist G and Receptionist E were supposed to ask the resident if they checked out with the nurse even if they were walking with family and stated they did double check with the nurse that the resident was signed out. The BOM stated that even if the family stated they checked out, they do have to double check. The BOM stated that residents should not go out the door alone and should be with someone. The BOM stated that the information reviewed with the receptionists included elopement procedure and explained that residents in the binder were at risk for leaving the facility. During an interview on 03/17/2025 3:57 PM, the MD stated that he was not under the impression that Resident #1 was approved to go out on pass on her own. He stated that the last time her personally saw Resident #1 was in December 2024 and he would not say Resident #1 had the capacity to leave the facility by herself based on what he documented at the point in time. The MD stated to the best of his knowledge it looked like that probably would not have been something he would have endorsed. During a telephone interview on 03/17/2025 at 4:22 PM, the DON stated that when Resident #1 attempted to elope on 02/06/2025 she was added to the elopement binder and she was placed on 15 minute checks daily until she discharged from the facility. The DON stated that Resident #1's hospice company assisted with providing a 1:1 sitter. The DON stated that Resident #1 was not exit-seeking when she first admitted to the facility. The DON stated that the purpose of the elopement binder was so that facility can see what the resident looks like and to know what residents may try to get out and to have extra eyes on those residents. The DON stated that normally residents who went on outings would tell the nurse and the nurse would take them out of the system and put them on therapeutic leave. The DON stated there was also a sign-out sheet at the front desk. The DON stated there is not a receptionist 24/7 but the receptionists were usually notified when they were there. The DON stated that the elopement binder was reviewed with Receptionist G and it was for her to have picture of resident who may try to elope and it was especially important because Receptionist G was new. The DON stated that anything could have happened to Resident #1 outside just like anyone else. The DON stated residents were currently in the elopement binder had exit seeking behaviors currently or may have been confused and tried to open a door to exit the facility. The DON stated they may not have tried to leave but just confused and try to go through the door. The DON stated residents were determined a risk for elopement if they wandered, pushed on exit doors. She stated Resident #1 pushed on an exit door and that is why she was considered an elopement risk. The DON stated that residents who wandered into other residents rooms were also considered an elopement risk. The DON stated if proceed was selected on the elopement assessment then the resident was considered and elopement risk. Review of the facility's policy titled Elopement with revision date of 11/01/2017 reflected that the policy is to safely and timely redirect patients/residents to safe environment. Review of facility in-service dated 02/23/2025 revealed covered topic of Elopements: All staff should review elopement binder and know what residents are in the binder When a door alarm goes off, it is the nurses responsible to verify all residents are in the building. Further review reflected Receptionist G did not sign the in-service. Review of the facility's policy titled Day Outings/Therapeutic Leaves of Absence with revision date of 11/01/2017 reflected residents may leave the facility for a day outing or therapeutic leave of absence with family or friends at any time with written permission from their physician. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ADM was notified on 03/17/2025 at 5:04 PM that an IJ had been identified. An IJ template was provided and a POR was requested. The following POR was approved on 03/18/2025 at 10:25 AM and indicated: Plan of Removal F689_ 3/17/25 Resident #1 no longer resides at the facility. Elopement Risk evaluations done in the past 90 days on current residents inhouse will be reviewed by Director of Nursing/Designee for accuracy by 3/18/25. Residents identified at risk will be reviewed for appropriate interventions including placement in the Elopement Binder and validated care plans have interventions listed. The Director of Nursing was reeducated by the Clinical Consultant on 3/17/25 on Accidents and Incidents including: elopement risk and the elopement binder when a resident is identified as an elopement risk, education will be provided to facility staff to alert them of a new resident listed in the elopement binder validating that when a resident is leaving the facility the nurse is aware and the resident and/or responsible party has signed the resident out for leave of absence elopement risk assessment process and putting interventions in place based on risks identified. All Facility Staff will be reeducated by 3/18/25 by the Director of Nursing/Designee on Accidents and Incidents including: elopement risk and the elopement binder when a resident is identified as an elopement risk, education will be provided to facility staff to alert them of a new resident listed in the elopement binder validating that when a resident is leaving the facility the nurse is aware and the resident and/or responsible party has signed the resident out for leave of absence Licensed Nurses will be reeducated by 3/18/25 by the Director of Nursing on the elopement risk assessment process and putting interventions in place based on risks identified. Any staff not receiving this education by 3/18/25 will receive prior to working the next scheduled shift. This will be presented in New Hire Orientation. The Director of Nursing will randomly interview a minimum of 2 staff daily to validate understanding of elopement risk and elopement binder. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/Designee will review the facility activity report beginning 3/18/25 in clinical morning meeting to identify documentation and/or elopement risk assessments that may suggest a resident is exit seeking. If identified, the Director of Nursing/Designee will validate interventions are appropriate and care plan is updated. The Director of Nursing/Designee will review new admission elopement risk assessments in Clinical Morning Meeting beginning 3/18/25 for accuracy and interventions validated if indicated, including placement in the elopement binder and education to staff of new resident listed in the binder. The Medical Director was notified on 3/17/25 of the Immediate Jeopardy. An Ad Hoc Quality Assurance and Performance Improvement Meeting was held on 3/17/25 to discuss contents of this plan. Administrator will oversee compliance of this plan. Surveyor monitored the POR on 03/18/2025 as followed: During interviews on 03/18/2025 between 12:12 PM and 5:17 PM, with 1 DON, 2 RN (MDS Coordinators), 2 RNs, 7 LVNs, 1 Staffing Coordinator/CNA, 15 CNAs, 1 Social Worker, 1 Admission Director, 1 Activity Director, 1 Activity Assistant, 1 Maintenance Director, 1 Dietary Manager, 3 Dietary Cooks, 2 Dietary Aides, 7 Housekeeping staff, and 1 Laundry Aide, it was revealed that staff received an in-service either 03/17/2025 or prior to their shift on 03/18/2025 on elopement risks led by the Clinical Services Director and DON. Staff interviewed stated that the in-serviced covered topics like the Elopement Policy and how to identify residents at high risk for eloping. Staff stated the training emphasized being vigilant about all residents who might try to elope, that each nurse's station had an updated elopement risk binder for tracking these residents at risk for elopement along with information available at the front desk. Staff stated they were encouraged to question any resident observed near exit doors as part of this awareness of elopement. Nursing staff stated during the in-service part of their training included understanding what steps needed to be taken when a resident was flagged as potentially high risk for elopement to ensure staff knew if there was a new entry in the elopement binder. Nursing staff stated that the assessment process was also discussed; and stated it involved determining whether a resident was high risk for elopement from behavior patterns documented during reviews of medical records. If residents were deemed not an elopement risk, staff checked do not proceed which meant no further action is needed. If a resident were deemed not an elopement risk, staff checked proceed and would notify charge nurse and it would be documented on the 24-hour report which was reviewed daily by the DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff stated that a QAPI meeting was held, and staff discussed solutions regarding the plan of removal. The DON stated she reviewed past evaluations over 90 days concerning current residents identified as having high risk for elopement while confirming necessary interventions were incorporated into care plans- which included making sure those individuals were listed correctly within the Elopement Binder. DON stated she received training focused not only on accidents but also incidents of elopement and maintaining accurate documentation around residents at risk for elopement and nursing needs to ensure proper protocol was followed when resident left the facility temporarily. DON stated that staff was supposed to ensure responsible parties have signed out their loved ones properly upon departure. DON stated that going forward daily checks would involve random conversations between her and two other staff members who focused to reinforce knowledge about high-risk elopement residents and kept track through clinical morning reports highlighted existing documentation relevant towards identifying residents exhibiting exit seeking behaviors. The ADM was notified on 03/18/2025 at 6:09 PM that the IJ had been removed. While the IJ was removed, the facility remained out of compliance at a level of no actual harm that was not immediate jeopardy at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems.