

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/24/2024
NAME OF PROVIDER OR SUPPLIER Bel Air at Teravista		STREET ADDRESS, CITY, STATE, ZIP CODE 4105 Teravista Club Drive Round Rock, TX 78665	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>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.</p> <p>The facility failed to ensure Resident #1 did not elope from the facility on 08/22/24. She was found less than two hours later approximately one mile away at a gas station on a busy street. She had a fall which resulted in a swollen face and a cheek abrasion.</p> <p>This noncompliance was identified as PNC IJ. The deficient practice began on 08/22/24 and ended on 08/23/24. The facility had corrected the noncompliance before the survey began.</p> <p>This deficient practice placed residents at risk for, falls, injuries, and hospitalization .</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including cognitive impairment, unspecified dementia, history of fractures, muscle spasms, and shortness of breath.</p> <p>Review of Resident #1's admission MDS assessment, dated 05/06/24, reflected a BIMS of 3, indicating a severe cognitive impairment. Section D (Mood) reflected the behavior of wandering had not been exhibited.</p> <p>Review of Resident #1's quarterly care plan, dated 05/24/24, reflected she was at risk for falls related to impaired mobility with an intervention of keeping areas free of obstructions to reduce the risk of falls or injury. It further reflected she had the potential risk for elopement with an intervention of assessing her for elopement on admission, readmission, quarterly and with any significant changes.</p> <p>Review of Resident #1's quarterly Elopement Risk Assessment, dated 08/09/24, reflected she was a moderate risk for elopement due to her cognitive impairment and wandering aimlessly.</p> <p>Review of Resident #1's quarterly Fall Risk Assessment, dated 08/22/24, reflected she was a high risk for falls.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's progress notes, dated 08/22/24 a 6:56 PM and documented by RN A, reflected the following:</p> <p>[Resident #1] was in her room at 3:35 PM evening meds was administered. At 3:45-4:30 [Resident #1] was noted in activity room with other residents. At 5:25 PM while passing dinner tray, [Resident #1] was not in her room this nurse checked the bathroom and [Resident #1] was not in the bathroom. CNA working in 300 hall stated that did not see [Resident #1], roommate stated that ([Resident #1] took her parse [sic] and said I will be back shortly). This nurse alerted all staff at the station of [Resident #1] not in the room, staff start searching for resident in all the rooms and bathrooms, outside the building and around, as well as the next building (facility name) and staff driving out on the streets looking for her, second nurse's station also were looking for her, family called and notified . DON notified at 5:35 PM and 6:10 PM when family arrived at the facility, [Resident #1] was found the roadside on (road name) near the (gas station), by a passerby whom the (family member) reported called family member and told them that [Resident #1] is on the road side and has fallen. Then brought [Resident #1] to the facility . head to toe assessment completed, abrasion to left check [sic] with some dried blood, face swollen, resident was agitated, confused, and combative . EMS was called at 6:15 PM per family request .</p> <p>Observations made on 08/24/24 from 10:45 AM - 10:58 AM revealed the MRD testing all eight exit doors throughout the facility to ensure the alarms worked. Each door sounded appropriately at the door and at the nurses' station. The MRD utilized the door code to turn off the alarm at each door.</p> <p>Observation of facility video footage, dated 08/22/24 at 5:12 PM, revealed Resident #1 ambulating independently out the front door behind a family member.</p> <p>During an interview on 08/24/24 at 11:01 AM, LVN F stated he was the nurse weekend supervisor. He stated he had been briefed regarding the incident with Resident #1 and in-serviced by the DON . He stated Resident #1 had a history of ambulating around the building but never saw her attempt to leave or exit-see. He stated the facility does not have any residents that he has witnessed exhibiting any exit-seeking behaviors.</p> <p>During an interview on 08/24/24 at 11:55 AM, the DON stated he was notified immediately when Resident #1 could not be found. He stated he headed to the facility and advised his staff to keep searching. He stated she was found less than two hours later near a gas station . He stated she had fallen onto her knees and two pedestrians went to assist her and saw her phone in her purse and contacted the last person she had contacted (FM D). He stated she was sent to the hospital per family request and was assessed with no further injury. He stated she was still in the hospital while the family decided on which facility to send her to that had a locked unit. He stated she had no prior history of attempting to leave or any exit-seeking behaviors. He stated they initially thought she may have exited through a side emergency exit door, but they were all tested and in working condition. He stated after reviewing video footage they were able to observe her walking out the front door behind a family member . He stated all staff were in-serviced before their shifts.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/24/24 at 1:42 PM, the REC stated on 08/22/24 she was in the front area and had clocked in around 3:30 PM. She stated she was doing her normal work duties and did not witness Resident #1 by the front desk or leaving the facility. She stated she went to clock out around 5:45 PM and an aide asked if she had seen Resident #1. She stated all staff began looking for her. She stated she had a high-elopement risk binder at her desk and knew not to let any resident leave unless she knew they were allowed to sign out on pass. She stated that same day staff were in-serviced like crazy. She stated they were in-serviced on abuse and neglect, the elopement process, and exit door codes. She stated the door codes of the emergency doors (excluding facility entrance/exit door) should never be given out to family or residents.</p> <p>During an interview on 08/24/24 at 1:53 PM, LVN B stated she had been in-serviced before her shift on elopement, rounding on residents every two hours, answering call lights in a timely manner, and abuse and neglect. She stated if a resident was missing, she would notify the DON and ADM immediately. She stated the emergency exit side doors were not to be used unless there was an emergency. She stated she would never give the exit code out to anybody. She stated there were binders with high-risk elopement residents at the REC's desk as well as at each nurse's station.</p> <p>During an interview on 08/24/24 at 2:34 PM, LVN C stated she was not working the day Resident #1 left the facility. She stated Resident #1 sometimes talked about wanting to go to the bank but never exhibited any exit-seeking behaviors. She stated she had been in-serviced before her shift on abuse and neglect, elopement, and door codes. She stated if a resident could not be found, the DON and ADM needed to be notified immediately after she ensured all staff started searching. She stated she would call the REC to see if any residents had left the facility. She stated it was important to lay eyes on all residents every two hours to ensure all are accounted for. She stated the exit doors are not to be used unless there was an emergency.</p> <p>During an interview on 08/24/24 at 2:59 PM, RN A stated Resident #1 did not have a history of trying to leave the facility. She stated she never even talked about wanting to leave. She stated on 08/22/24, she last saw her around 3:45 PM when she gave her medication. She stated when she took her dinner tray to her room, she noticed she was not in there. She stated she immediately started searching for and asking staff members. She stated the CNA told her she had seen her in the activity room around 4:45 PM. She stated she went to the activity room but she was not in there. She stated she searched all rooms on her hallway, and contacted her family to ensure she was not with them. She stated at that time, all staff started searching the facility, outside, and the courtyard. She stated she contacted the DON and ADM. She stated shortly after, Resident #1's FM D called her and informed her that a passer-by found her by the gas station down the street and dialed the last person that had been called on Resident #1's phone (FM D). She stated she knew none of the exit door alarms had gone off and she knew she had not left through the side doors. She stated all staff were immediately in-serviced by the DON on elopement, who to notify, when you hear an alarm go off to do a head count your residents immediately, and knowing where they were at all times.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/24/24 at 3:11 PM, CNA E stated she was working the day Resident #1 left but was not working her hall. She stated she was familiar with Resident #1 and had never seen her attempt to exit the facility. She stated when it was noticed Resident #1 was missing on 08/22/24, everybody stopped what they were doing and started looking in all of the rooms, bathrooms and outside. She stated in-services conducted by the DON started that evening on elopement and exit doors. She stated it was important to check on the residents constantly and the residents that were a high-risk of elopement (per elopement binder) should be checked on more often. She stated the only door that should be used to enter/exit the facility was the front door.</p> <p>Review of an in-service entitled Building Entrances and Emergency Exits, dated 08/22/24 - 08/23/24 and conducted by the DON, reflected all staff were in-serviced on the following:</p> <p>Visitors and staff should be only utilizing the front entrance. Side doors are for emergency only and no persons should be coming in or going out of these doors.</p> <p>Review of an in-service entitled Elopement, dated 08/22/24 - 08/23/24 and conducted by the DON, reflected all staff were in-serviced elopement procedures.</p> <p>Review of an in-service entitled Abuse and Neglect, dated 08/22/24 - 08/23/24 and conducted by the DON, reflected all staff were in-serviced abuse and neglect.</p> <p>Review of an in-service confirmations, dated 08/22/24 - 08/23/24, reflected all staff signed an attestation form that they were in-serviced on the following:</p> <p>Elopement and missing persons, shift change walking rounds, Q2 hours body count and sign offs, procedure for missing/elopement patients - q 15 shift, how to identify change in condition, i.e. exit seeking and who to report it to.</p> <p>Review of an audit conducted by the DON, on 08/22/24, reflected all residents had a new elopement risk assessment conducted and no residents were deemed as a high risk.</p> <p>Review of the facility's Elopements policy, revised December of 2007, reflected the following:</p> <p>Staff shall investigate and report all cases of missing residents.</p> <p>1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.</p> <p>This noncompliance was identified as PNC. The deficient practice began on 08/22/24 and ended on 08/23/24. The facility had corrected the noncompliance before the survey began.</p>		