STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455532	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant Springs Healthcare Center	2003 N Edwards St Mount Pleasant, TX 75455

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** 44637 Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards and each resident was provided adequate supervision to prevent injuries for 1 of 6 residents (Resident #1) reviewed for accident hazards. The facility failed to ensure Resident #1's freestanding closet was secured to the wall resulting in him pulling it down on top of his self when he fell on [DATE]. The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for injury and death. Findings include: 1. Record review of the face sheet dated [DATE] indicated Resident #1 was an [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses including orthostatic hypotension (a form of low blood pressure that happens when standing up from sitting or lying down), heart failure (a chronic condition in which the heart does not pump blood as well as it should), muscle weakness, abnormalities of gait and mobility (an deviation from a normal walking pattern), and history of falling. Record review of the MDS dated [DATE] indicated Resident #1 understood others and was understood by others. The MDS indicated Resident #1 had a BIMS of 08 and was moderately cognitively impaired. The MDS indicated Resident #1 was independent with dressing, personal hygiene, and transfers. Record review of the care plan dated revised on [DATE] indicated Resident #1 was at risk for falls related to impaired vision, history of falling, and weakness with intervention in place including educating Resident #1 on using his call light, call don't fall signs in Resident #1's room, keeping Resident #1's call light within reach, medication reviews, ensuring Resident #1 wore appropriate footwear, and keeping Resident #1's room free of clutter. Record review of an Incident report dated [DATE] indicated Resident #1 had inwitnessed fall and was found in the floor by a CNA. The iIncident report indicated Resident #1 said I was trying to see if my speaker was on and I fell backwards. I landed on my head, I think I broke it. The incident report indicated Resident #1 was transferred to the hospital due to hitting his head, (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 an incident report dated [DATE] indicated Resident #1 had an unwitnessed fall. The incident report indicated, Responded to resident call light, resident was discovered on the floor in their room. upon assessment resident stated I tried to get to the bathroom from my bed and my legs gave out on me. Resident stated I hit my head on the recliner arm. Upon EMS arrival resident was noncompliant with going. Resident stated I will not go, you have me damned if I do. This nurse educated resident on risks from injury's, resident stated It's just a scrape, I'll be fine. Record review of the Nurse's Progress note dated [DATE] indicated, [the] nurse observed [Resident #1 lying] flat on the floor with the closet toppled over and door was laying on [Resident #1's] left side with head on bottom of bedside table with blood observed on bedside table. [The] nurse and a CNA picked up the closet off of the resident to assess and help resident. Resident was bleeding from a laceration to the back of the head .Resident stated, I was trying to get clothes out of the closet and lost my balance and tried to catch the closet to keep from falling. Resident alert to person and place and time. Resident sent to the ER for further evaluation from the fall due to severity of bleeding and of the closet being toppled over . Record review of the Nurse's Fall Note dated [DATE] indicated Resident #1 had an unwitnessed fall and was discovered in his room with the closet on top of him. The note indicated Resident #1 hit his head when he fell . The Nurse's Fall Note indicated the closet was picked up off Resident #1, pressure was applied to the back of head his head, and he was sent to ER for further evaluation. The Nurse's Fall Note indicated [Resident #1] stated I just lost my balance looking in the closet for pants and I fell holding onto the closet. The Nurse's Fall Note indicated Resident #1 refused to call for help. Record review of the hospital records dated [DATE] indicated Resident #1 had a diagnosis of subdural hematoma (a pool of blood between the brain and its outermost covering). The hospital records indicated Resident #1 had multiple falls. The hospital records indicated Resident #1 started having an altered level of consciousness and was found to have a right subdural hematoma. The hospital record indicated Resident #1's neuro exam deteriorated at the other hospital and became unresponsive a was transferred to this hospital. The hospital records indicated a cat scan at this hospital showed worsening of the right subdural hematoma. The hospital records indicated Resident #1 was in critical condition with the extremely poo prognosis, however his only chance of survival was an immediate craniotomy (a surgical procedure that involves removing a piece of the skull to access the brain). The hospital records indicated Resident #1's was sent to the OR for emergent craniotomy. The hospital record indicated Resident #1 expired on [DATE]. (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 [DATE] at 2:10 p.m. the Administrator said on [DATE] at approximately 1:00 a.m. the charge nurse heard a loud noise from Resident #1's room. The Administrator said when the nurse entered the room the resident was lying in the floor with the closet on top of him and door to the closet open. The Administrator said Resident #1 told the nurse he was trying to get some pants, lost his balance, and pulled the closet down with him. The Administrator said the nurse assessed the resident and made the decision to send him to the ER. The Administrator said the charge nurse received a call from the local ER reporting Resident #1 had a subdural hematoma and was being transported to a [NAME] hospital. The Administrator said the family had informed the facility Resident #1 expired at approximately 6:00 pm on [DATE] shortly following surgery. The Administrator said the facility had been informed Resident #1's prognosis was poor. The Administrator said they have requested medical records from both hospitals but had not yet received them. She said she did not believe Resident #1 was taking any blood thinning medication. She said he had a history of falls, was independent, and refused all fall interventions the facility tried to put in place. During an observation and interview on [DATE] at 2:20 p.m. the closets observed in the room were free-standing heavy-duty cabinet/wardrobes. The Administrator said the closets were not secured to the wall at the time of the incident. The Administrator said she had never had a resident pull one of the closets down. The Area Manager said since the incident they have secured all the closets in the building to the walls with L-brackets attached to the wall and the top of the closets. Record review of the facility's Falls/Ambulation policy dated 2003 indicated, .Risk factors should be assessed upon admission and thereafter as necessary .Risk factors include: 1. level of consciousness/mental status 2. history of falls 3. ambulation/elimination status 4. vision status 5. gait/balance 6. systolic blood pressure (the pressure in the arteries when the heart contracts and pumps blood) 7. Medications 8. predisposing diseases . Reducing Environmental Hazards . Record review of the facility's Preventive Strategies to Reduce Fall Risk policy revised [DATE] indicated, The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the residents' mobility. The facility will complete a fall assessment on each resident at the time of admission to the facility. The Fall Assessment Tool will be used to assess the resident's risk of falls until completion of the MDS assessment. The comprehensive MDS assessment will assist in identifying those residents at risk for falls. Residents at risk will be care planned for fall prevention .Incident reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s) .Environment: Keep bed in low position. Keep the bed wheels locked. Use mobility handles or ,d+[DATE] rails in bed, low bed, scoop mattress bolsters, or any combination of the previous. Place the call light and other objects within easy reach. Use bed/chair alarm systems to monitor unsafe activity as needed. Maintain adequate illumination in bedrooms and bathrooms. Maintain nonslip floor surface. Keep hallway clear. Provide grab bars and toilet risers in the bathroom . The Administrator was notified on [DATE] at 11:57 a.m. that a Past Non-Compliance Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on [DATE] at 12:00 p.m. The facility had corrected the noncompliance by the following: Securing all free-standing closets to the wall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-servicing staff regarding fall prevention and monitoring closets for being secured to the wall Monitoring risk management for hazards during daily stand-up meeting 5 days a week for 6 weeks Monitoring all free-standing closets for being secured to the wall 5 days a week for 6 weeks. The surveyor confirmed the facility had corrected the non-compliance prior to survey starting by: [DATE] Observed free-standing closets in Resident #1's room, the closets were secured to the wall by an L-bracket. The Administrator said all free-standing closets in the facility had been secured to the walls. * [DATE] Observed free-standing closets in 8 randomly selected resident rooms to ensure they were secured to the wall. Staff interviewed (LVNA A, RN B, ADON, CNA C, CNA D, CNA E, MA F) on [DATE] between 10:08 a.m. and 11:00 a.m. were able to answer all question regarding in-services including fall precautions including beds in low position, call light in reach, fall mats at bedside, call don't fall signs, and appropriate footwear to be put in place, fall assessments to be performed quarterly and following each fall incident, monitoring free-standing closets to ensure they are secured to the wall, reporting to maintenance or the Administrator if a free-standing closet becomes unsecured to the wall or broken. Record review of risk management monitoring check-off Record review of free-standing closet monitoring check-off.