STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455575	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center	2322 Morgan Ave Corpus Christi, TX 78405

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on observation, interview and record review, the facility failed to ensure the right to be free from abuse for one (Resident #62) of two residents reviewed for abuse. The facility failed to ensure Resident #62 was free from abuse. On 10/24/24, Resident #60 hit Resident #62 in the head with a grabber because Resident #62 would not stop touching it. This failure could place residents at risk for abuse and psychological harm. Findings included: Record review of Resident #60's face sheet revealed a [AGE] year-old male with an admitted d of 06/20/19. Diagnoses included dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, high blood pressure, depression, mood disorder, and abnormalities of gait and balance. Record review of Resident #60's Annual MDS, dated [DATE], reflected a [AGE] year-old male who admitted on [DATE]. His BIMS score of 15 indicated the resident had no cognitive impairment with inattention and disorganized thinking. He required supervision for all ADL's. He could walk supervised with the use of a walker. He had a manual wheelchair and could self-propel. He was frequently incontinent of urine and frequently incontinent of bowel. Record review of Resident #60's Care Plan dated 06/21/19, reflected Resident #60 had potential to be physically aggressive with fell ow roommate (Resident #62). Resident #60 was in a resident-to-resident altercation when his roommate was touching his personal belongings. Interventions included on 10/24/24, Resident #60 was placed on 1:1, psyche services contacted, and new orders for medication were received and implemented. Record review of Resident #62's face sheet revealed a [AGE] year-old male with an admitted [DATE]. Diagnoses included Alzheimer's Disease, dementia, and depression, and had a dependence on wheelchair due to a left knee contracture. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #62's annual MDS Assessment, dated 10/30/24, reflected his BIMS score of 09 indicated the resident had moderate cognitive impairment with inattention and disorganized thinking. He required substantial assistance with eating, dressing, personal and oral hygiene. He was dependent for toileting, showering, transferring, and footwear. He utilized a manual wheelchair and required assistance to propel. He was always incontinent of bladder and bowel. He did not display any behaviors at the time (look back period) of the MDS assessment. She took antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. Resident #62's quarterly care plan dated 02/19/25 reflected Resident #62 was involved in resident-to-resident altercation secondary to reaching for another resident belongings Date Initiated: 10/24/2024. Interventions included o 10/24/24 Room change made and placed on immediate one to one Date Initiated: 10/24/2024 o Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 10/24/2024. o Give the resident as many choices as possible about care and activities. Date Initiated: 10/24/2024. Record review of PIR dated 10/29/24 revealed R#60 hit R#62 with his grabber causing redness to his forehead that resolved immediately. Increased supervision (1:1) on R#60. R#62 moved to another room at his request. The PIR confirmed the findings. Resident #60 stated he did hit him after he would not leave his grabber alone. Police report done case #2410240122. Intervention: resident placed on immediate one to one and room change made. Record review of all staff in-services dated 10/24/24 for Resident-to-Resident Altercation and Abuse & Neglect. Observation and interview with Resident #60 on 03/26/25 at 3:04 pm revealed a well kempt cheerful male, lying in bed with eyes closed and TV on. He readily awoke to his name and said he was doing fine. He denied any kind of ever having an altercation with anyone. He said no one messes with him. He said he was tired of rules and wanted to get an apartment. He said 7 years was long enough.(Admission 06/19/21) He said everyone was good to him here. Observation and interview with Resident #62 on 03/26/25 at 3:16 pm he denied any altercations with any CNA. He said this surveyor was mistaken, even though he was reminded of the altercation he had with his roommate on 10/24/24. In an interview with the SW on 03/26/25 at 1:40 pm, she said Resident #60 did not like to bathe. Sometimes he would curse at others-he was grumpy. He will sit in his own urine until after I get my smoke break or other excuse. He had been through several roommates due to his lack of hygiene, this last time, he was now in a room by himself. She said she spoke to him and he did not have any issues or duress. She said his demeanor was calm and had been since the incident. He had not had any situations since then. She said she met with both residents for a 3 day follow up. She said Residents #60 and #62 were calm. She said Resident #60 was talkative, in a good mood and was around at activities downstairs. She said Resident #62 did not appear to be in distress at any time. She said no behavior incidents have been reported. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 03/27/25 at 8:45 am, she said she was familiar with both gentlemen. She said Resident #60 had behaviors and it was unfortunate it was not witnessed and was not sure how to prevent that. She said the quote in the PIR sounded like something Resident #60 would say. She said Resident #62 did not have any complications because of the altercation. She said they moved Resident #60 to a room by himself and have not had any further incidents since then. She said one of the interventions she requested was a medication review which the pharmacist and doctor did, (verified) and to keep monitoring him. She said someone was requesting assistance to the resident's room regarding a resident being hit on the forehead with another resident's grabber. She stated she was told by another resident it sounded like someone was arguing. She said she heard shouting and went to the room and found Resident #60 cursing at Resident #62. Resident #60 stated Resident #62 was getting his grabber and he has already stated over and over, don't touch it. Resident #60 said, I've already told this other m r o to quit touching my shit and he doesn't stop so I whacked him with it. The DON said Resident #62 was removed from the room immediately. She said he was unable to verbally give a description of what occurred but able to point to his left front forehead to indicate where he was hit with the grabber. Resident #60 was removed from the room and placed on immediate one to one as per facility protocol. She said a head-to-toe assessment was performed and a small, reddened area was noted to Resident #62's left front side of his forehead that disappeared over 5 mins. She said Resident #62 denied any pain, his vital signs were all normal, and there were no other areas noted. Neuros initiated. In an interview with the ADM on 03/27/25 at 3:07 pm, she said Resident #60 was intentional when he hit Resident #62 on the head. She said Resident #60 did not always get mad, and staff were using nursing judgement and placed him on 1:1 to protect others from him. She said they were roommates at the time. She said Resident #60 did not always have aggression daily and he could be very nice. She said since that incident, they moved Resident #60 to a room by himself and he had not had any incidents since. Record review of the facility policy titled, Abuse, Neglect, and Exploitation dated 08/15/22 defines abuse as the willful infliction of injury or intimidation. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Record review of all staff in-service/training dated 07/26/24 titled Abuse & Neglect: Resident to Resident altercation-how, when, why, and where with ANE policy dated 08/15/22. Resident Rights dated 07/26/24.

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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	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** 44748 Based on interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 2 of 3 Residents (Residents #62 and #61) reviewed for Abuse, and Injury of unknown source. 1. The facility did not report an allegation of abuse per facility policy to the Administrator regarding Resident #62 on 02/24/25 until 02/28/25. 2. The facility failed to ensure CNA ZZ reported an allegation of injury of unknown sources per facility policy to the Administrator regarding Resident #61 on 11/24/24 until 11/26/24. This deficient practice could affect any resident and could contribute to further neglect. The findings included: 1. Record review of Resident #62's face sheet dated 03/14/25 revealed an [AGE] year-old male with an original admitted [DATE]. Diagnoses included stroke with subsequent weakness to the right dominant side, dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, high blood pressure, diabetes, heart disease, kidney disease, anxiety, insomnia (difficulty sleeping), aphasia (difficulty speaking), and depression. Record review of Resident #62's quarterly MDS Assessment, dated 02/26/25, reflected an [AGE] year-old male who readmitted on [DATE]. His BIMS score of 00 indicated the resident had severe cognitive impairment with inattention and disorganized thinking. He could not speak, was rarely/never understood, had short- and long-term memory problems, and he was severely cognitively impaired for decision making. He required set-up assistance with eating, moderate assistance with oral and personal hygiene, showering, and upper body dressing. He required substantial assistance with toileting, lower body dressing, and footwear. He required moderate assistance with transferring and positioning, and supervision to stand and walk. He did not utilize a wheelchair. He was frequently incontinent of urine and always incontinent of bowel. 2. Record review of Resident #61's face sheet revealed a [AGE] year-old male with an admitted [DATE]. Diagnoses included Alzheimer's Disease, dementia, depression, anorexia, and had a dependence on wheelchair due to a left knee contracture. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #61's annual MDS Assessment, dated 10/30/24, reflected his BIMS score of 09 indicated the resident had moderate cognitive impairment with inattention and disorganized thinking. He required substantial assistance with eating, dressing, personal and oral hygiene. He was dependent for toileting, showering, transferring, and footwear. He utilized a manual wheelchair and required assistance to propel. He was always incontinent of bladder and bowel. He did not display any behaviors at the time (look back period) of the MDS assessment. He took antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. Record review of Resident #61's shower sheet dated 11/25/24 indicated bruising to the left shoulder and left hip. Record review of Resident #61's pain evaluation dated 11/26/24 at 7:21 am indicated the resident had no complaint of pain in the last 5 days. Record review of Resident #61's wound evaluation dated 11/26/24 at 8:14 am signed by the wound care nurse indicated a new left shoulder bruise acquired in-house. Area 140.46 cm 2, length 22.14 cm, width 7.49 cm. non-pitting edema extends < 4 cm around wound. Temperature normal. Cognitively impaired, Relaxed, pain score 0, denied pain when asked in Spanish. No dressing was applied. Intact bruising dark purple in color. Possible edema to the shoulder area, skin intact. Also indicated was a 5 x 9 inch bruise to the left hip. In an interview with CNA ZZ on 03/26/25 at 10:11 am, she said she knew Resident #61 and worked with him on 11/24/24 through 11/26/24. She said she did not report the bruising she saw on Sunday, 11/24/24, because she thought it had already been reported since it was a good size area and because he did not complain of pain. She said the bruise looked faded and old. She said it was purple, not red, not yellow, but already fading. She said Resident #61 had an old bruise on the left side of his hip on that day (Sunday). She said a couple of hours after the first time she saw the shoulder bruise, she told the DON. She said the DON asked Resident #61 if he had fallen during the night several times, but he never indicated yes or no. She said the DON performed a full body assessment and both bruises were there on the left. She said the bruising was bigger on Tuesday (11/26/24) compared to the day before. In an interview with the wound care nurse on 03/26/25 at 4:40 pm she said she knew Resident #61. She said she conducted the 11/26/24 wound evaluation for his shoulder and his hip. She said she was not informed about the bruising until the 26th. She said her understanding of the situation was he tripped in his room. She said she could not recall how she received that information. She said the resident's dementia had worsened and he had been having more falls lately. She said staff tried to keep him in a wheelchair close by when awake. She said his fall mat was in place, and his bed was low. She said his call light was within his reach, and he was wearing non-skid socks. She said any bruising should be reported immediately. She said she should have been made aware on Monday the 25th. She said her last ANE training was a week or two ago. She said the in-services taught how, what, and when to report any kind of abuse. She said the types of abuse were physical, verbal, exploitation, and neglect. In an interview with the DON on 03/27/25 at 10:37 am, she said Resident #61 could not speak. She said he has had multiple falls. She said she had the wound care nurse go with her to assess the resident. She said staff were trained to report immediately and show on their shower sheets any discolorations. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 03/27/25 at 1:24 pm, she said alleged abuse or neglect should be reported right away and the allegations were not reported timely. She said staff were trained often in abuse, neglect, and reporting. She said staff did not report the allegation of abuse for Resident #62 because he did not tell them, and the incident was unwitnessed. She said she did not know why staff did not report the allegation of injury of unknown sources regarding Resident #61. Interviews beginning on 3/25/25 at 8:30 am, five CNA's, five LVN's, and 1 housekeeper were all able to identify the different types of ANE and who to report it to if suspected. All staff stated they did not suspect ANE at the facility. They all said they had abuse, neglect and reporting in-services frequently either in-person or on the computer. They all said they had been trained within the last week to within the last month. Record review of Resident #61's Change of Condition form dated 11/24/24: Noted resident to have a 5x9 red/purple discoloration to Right lateral buttock; resident unable to clearly verbalize discomfort, however at this time no signs/symptoms of pain; no changes in ADL's; continues to ambulate independently with no issues at this time. Record review of the facility policy titled, Abuse, Neglect, and Exploitation dated 08/15/22 defines abuse as the willful infliction of injury or intimidation. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. VII. Reporting/Response A. 1. Reporting of all alleged violations to the Administrator, state agency .within specified timeframes: b. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegations involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44748 Based on interviews, and record reviews, the facility failed to ensure that the comprehensive care plans were reviewed and revised by the interdisciplinary team after each assessment, for two residents (Resident #3 and Resident #61) of 20 residents whose care plans were reviewed, in that: 1) Resident #3's comprehensive care plan was not revised to reflect Resident #3 had a history of trying to give money to residents and staff. 2) Resident #61's comprehensive care plan was not revised to reflect interventions for Resident #61 who had a history of falls. These failures could place residents at risk for inadequate care, accidents, and injuries. The findings included: 1.Record review of Resident #3's face sheet dated 03/26/25 reflected an [AGE] year-old-female with an original admitted [DATE]. Diagnoses included Alzheimer's Disease (brain disorder that affects memory, thinking, behavior and everyday skills) and depression (mood disorder that causes persistent feelings of sadness and loss of interest). Record review of Resident #3's quarterly MDS dated [DATE] reflected a BIM score of 6 (severe cognitive impairment). In an interview on 3/27/25 at 10:00 am the DON stated if Resident #3 had a change in condition, that behavior or change should have been care planned. The DON stated any resident changes were discussed in morning meetings. The DON stated care plans were a team effort and the MDS Coordinator as well as the nurses, the ADONs, the DON and social services can update the care plans. The DON stated Resident #3's care plan was overlooked and should have been care planned because care plans are an individualized plan of care that provide specific care residents need, and so staff can be aware of any changes or behaviors. The DON stated the policy stated the MDS Coordinator and ADON's were responsible for updating the care plan. The DON stated ultimately the responsibility of making sure the care plans were accurate and updated was the DON but was a team effort. In an interview on 3/27/25 at 2:10pm ADON A stated MDS Coordinator or nurses could update a care plan as soon as a new behavior or change of condition was noted. ADON A stated Resident #3's behaviors of trying to give money to residents and staff should have been care planned to let all staff know of Resident #3's history of behaviors and individualized plan of care. In an interview on 3/27/25 at 3:24pm the ADM stated the DON and MDS were ultimately responsible to ensure that resident care plans were accurate. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/27/25 at 4:03pm the MDS Coordinator stated behaviors such as trying to give residents or staff money should be care planned. The MDS Coordinator stated repetitive behavior that could lead to an issue and any repeated episodes from a resident should be care planned so staff were aware. The MDS Coordinator stated care plans were an individualized plan of care. The MDS Coordinator stated there was no reason Residents #3 and #61's behaviors were not care planned and was overlooked. 2.Record review of Resident #61's face sheet dated 03/14/25 revealed an [AGE] year-old male with an original admitted [DATE]. Diagnoses included stroke with subsequent weakness to the right dominant side, dementia (disease that results in loss of memory, language problem, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle wasting, high blood pressure, diabetes, heart disease, kidney disease, anxiety, insomnia (difficulty sleeping), aphasia (difficulty speaking), and depression. Record review of Resident #61's quarterly MDS Assessment, dated 02/26/25, reflected an [AGE] year-old male who readmitted on [DATE]. His BIMS score of 00 indicated the resident had severe cognitive impairment with inattention and disorganized thinking. He could not speak, was rarely/never understood, had short- and long-term memory problems, and he was severely cognitively impaired for decision making. He required set-up assistance with eating, moderate assistance with oral and personal hygiene, showering, and upper body dressing. He required substantial assistance with toileting, lower body dressing, and footwear. He required moderate assistance with transferring and positioning, and supervision to stand and walk. He did not utilize a wheelchair. He was frequently incontinent of urine and always incontinent of bowel. Record review of Resident #61's Care Plans dated 01/18/23, 11/25/24, 08/21/24, and 03/08/25, reflected Resident #61 was o at risk for falls r/t Confusion, Unaware of safety needs Date Initiated: 01/16/2023 Revision on: 01/16/2023 o will be free of minor injury through the review date. Date Initiated: 01/16/2023 Revision on: 02/12/2025. o Anticipate and meet the resident's needs. Date Initiated: 01/16/2023. o Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Date Initiated: 01/16/2023 Revision on: 01/16/2023 Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. Date Initiated: 01/16/2023 Revision on: 01/16/2023. There were no further updates for fall preventions. In an interview with DON on 03/27/25 at 10:37 am, she said Resident #61 had a history of multiple falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He had been progressively declining for some time, and he had been placed on hospice. She said fall preventions/interventions for Resident #61 included putting a helmet on him, fall mat, frequent rounding (meaning staff knew that Resident #61 was one of their focused, more likely fall risk residents), and monitored them a lot closer. She said they had to respect the residents' rights. She said they could not make the residents stay in their beds. She said the interventions she named were care planned. She said falls should be under falls. She said there were no interventions on his care plans related to helmet, low bed, or fall mat, or non-skid socks. She said IT tickets showed they were losing documentation, but that was 2 weeks ago. She said putting a helmet on Resident #61 was entered today, 03/27/25. She said the other interventions were not care-planned. She said the policy said MDS was responsible for updating care plans, but the unit manager (ADON), herself, and primary care nurses were supposed to be updating care plans as well. She said she was ultimately responsible for ensuring the care plans were updated, accurate, and done. She said management discussed person centered care planning in the daily morning meetings and the primary care nurse should update immediately, the ADON's monitor them on their unit, then she monitors them both. She said interventions were discussed for Resident #61 but they were never entered, and she did not know why. She said the interventions in Resident #61's care plans were not dated. She said his fall risks were high because his son did not want to have any surgery done. She said the son told her he did not want the resident going to the hospital anymore because it triggered Resident #61's PTSD. (PTSD not in medical records). She said a diagnosis of PTSD would be significant information and should be in his care plan. In an interview with the ADM on 03/27/25 at 3:13 pm, she said Resident #61 had PTSD (Post Traumatic Stress Disorder) from the Navy. She said she assumed PTSD needed to be in the care plan and diagnoses so staff could understand the resident's behaviors. She said she did not know why PTSD was not in Resident #61's care plan or diagnoses because she was not his nurse. She said the nurses were responsible for the care plans. She said her responsibility regarding care plans was making sure they were done and updated. She said she was under the impression the nurses were updating care plans during the daily morning meetings. She said the DON should be checking the nurses' updates. She said Resident #61 was one of her frequent fallers. She said interventions such as non-skid socks, floor mat, wheelchair, and placing him on 1:1 were listed in his care plan. She said she and regional administration started monthly audits in 01/2025 such as nutrition, infection control, dietary, etc., but did not know if care plans were on that list. She said MDS was part of the IDT, and the IDT team were responsible for updating care plans. She said MDS entered comprehensive care plans and nurses/ADON's entered the updates. Record Review of the facility's Care Plan Revisions Upon Status Change reflected: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. d. The care plan will be updated with the new or modified interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. 46038

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	455575	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Retama Manor Nursing Center	2322 Morgan Ave Corpus Christi, TX 78405

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F 0689 Level of Harm - Actual harm 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** 49157 Based on interview and record review the facility failed to ensure residents' environment remained as free of accident hazards as is possible; and residents received adequate supervision and assistance devices to prevent accidents for one 1 of 5 residents (Resident #9) reviewed for accident hazards. The facility failed to ensure that on 12/16/24 the PTA supervised and did not leave Resident #9 unattended in her wheelchair which allowed Resident #9 to fall out of the wheelchair onto the floor where she sustained a hematoma (a closed wound where blood collects and causes swelling because it cannot drain out) above and a laceration (cut) next to her left eyebrow. This failure could result in residents not receiving appropriate supervision leading to falls, injuries, or hospitalization . The findings included: Record review of Resident #9's admission record reflected a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (a condition in which the blood flow to the brain is interrupted causing brain tissue to die), lack of coordination, muscle wasting, dementia (a term for several diseases that affect memory, thinking, and the ability to perform activities of daily living), cognitive communication deficit (difficulty understanding or producing language and non-verbal communication skills), and dysphagia (difficulty swallowing). Record review of Resident #9's admission MDS dated [DATE] reflected a BIMS score of 0 which indicated that Resident #9 was severely cognitively impaired. Resident #9 was dependent for ADL's including toileting, shower/bathing, dressing, and personal hygiene. Record review of Resident #9's initial nursing evaluation dated 11/12/24 reflected Resident #9 used a manual wheelchair and a walker prior to admission to the facility and required substantial/maximal assistance to stand up from a sitting position. Record review of Resident #9's fall risk evaluation dated 11/12/24 reflected she had a history of 3 or more falls in the previous 3 months, she required the use of assistive devices (wheelchair, walker), and her total score was 25 which indicated she was at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's care plan dated 11/13/24 reflected a problem of a risk for falls related to confusion, incontinence, poor communication/comprehension, psychoactive drug use, and unaware of safety needs with a goal of resident would not sustain serious injury through the review date and the interventions included ensure the call light was within reach, encourage use, and respond promptly to requests for assistance, frequent rounding to ensure safety, and PT evaluate and treat as ordered or as needed. Resident #9's care plan also reflected a problem of an actual fall dated 11/18/24 (minor injury- bruising to right eyebrow), 12/16/24 (hematoma above left eyebrow with laceration on side of left eyebrow) and 02/15/25 (no injury). The goals included discoloration to right eyebrow would resolve with complication (initiated 11/18/24) and the resident's hematoma and laceration above left eyebrow would resolve without complication (initiated 12/16/24). The interventions included PT consult for strength and mobility (initiated 11/18/24), staff was to anticipate resident's needs, frequent rounds were to be done by staff (initiated 11/18/24), resident was to be supervised when in therapy room (initiated 12/16/24), and staff was to monitor/document/report PRN for 72 hours to MD for s/sx: pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture or agitation (initiated 12/16/24). Record review of Resident #9's progress notes dated 11/22/24 to 12/23/24 reflected the following entries: Effective date: 12/16/24 at 1:37pm, Type: Change of Condition by LVN C. Resident had an unwitnessed fall, hematoma to above left eyebrow and small laceration next to left eyebrow, started 12/16/24, since started it has gotten: stayed the same. Things that make the condition worse: leaning forward in chair. Things that make the condition better: repositioning and watching resident. Resident likes to reach out from w/c, she overreaches at times. Effective date: 12/16/24 at 1:32pm, Type: Nurse note by LVN C. Note text: Therapy called nurse into therapy room, therapist stated to nurse resident had fallen out of her wheelchair, they did not witness the fall but seen her laying down on the floor on her left side. While on the floor writer checked vitals and seen she had a small laceration near eyebrow and a hematoma forming above left eyebrow. Applied light pressure with gauze, called the NP and reported incident, given orders to send out d/t possible head injury. Writer kept resident in a supine position on the floor until ambulance arrival while supporting neck and head. EMS arrived and transferred to stretcher and taken to [the hospital]. Writer called family and spoke with [RP] and will meet at hospital. Effective date: 12/17/24 at 4:51am, Type: Nurse note by LVN D. Note text: Patient (Resident #9) returned from hospital at 6:40pm, patient was taken to room, no issues noted with patient, all vitals within baseline, patient remained asleep throughout the night. Record review of Resident #9's after visit summary from the ER dated 12/16/24 reflected that she was seen for a fall from chair, and she had no broken bones. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #9's radiology report for a CT scan of her head and face dated 12/16/24 reflected Resident #9 had a large left frontal (on the front) and periorbital (around the eye) soft tissue hematoma. Record review of the undated written statement by the COTA reflected, To whom it may concern, I was seated in the therapy breakroom with coworkers when I heard a thump and turned and witnessed the patient (Resident #9) on the floor. The therapist got up immediately to check on the patient who was laying on the ground in front of her wheelchair. Patient's nurse immediately came to assess patient with aid. Record review of the written statement by the OTR dated 12/16/24 reflected, I was eating lunch in the breakroom (unaware there was a patient was in the gym) when we heard a loud noise. [The COTA] look out of the break room door way to assess the source of the noise and said, Oh no!, immediately stood up and ran into the main gym room. [The DOR] and I immediately followed and observed the patient, [Resident #9] to be on the ground in front of her wheelchair. While [the COTA] and I remained with the patient, [the DOR] immediately reported to the nurse (LVN C) who entered the gym shortly after. Patient was directly handed off to nursing. [sic] Record review of the written statement by the DOR dated 12/16/24 reflected, I was in the copy room when I heard [the COTA] say patient (Resident #9) is on the floor. I immediately went to check on the patient. I went immediately to get the charge nurse, which nursing assessed patient and provided care. Patient was left in nursing care. In an interview on 03/26/25 at 10:04am CNA E stated a little after lunch, Resident #9's FM was pushing the resident in her wheelchair toward the nurse's station so they could speak with the nurse. CNA E stated when she asked Resident #9's FM if they would like for her to take Resident #9 to her room, the FM stated that therapy wanted to work with Resident #9, so she took her over to the therapy room. CNA E stated when she got to the therapy room, the OTR was sitting on the stool and the PTA was over in the corner area. CNA E stated the OTR was messing with the foot things and she left Resident #9 there in front of the OTR and went back to the hall and the next thing she knew, they said Resident #9 had fallen. CNA E stated Resident #9 was very active that day, moving around in her wheelchair and that they normally keep her wheelchair tilted back. In an interview on 03/26/25 at 2:20pm the DOR stated she was in the copy room when she heard the COTA say the patient was on the floor so she got up to help, and immediately went and got the nurse. The DOR stated she believed that a miscommunication between the PTA and the COTA is what lead to Resident #9's fall. The DOR stated that her understanding was the PTA had asked the COTA to watch Resident #9 while he took another resident out of the therapy area, but the COTA did not hear him. The DOR stated the COTA was in the gym documenting and that CNA E may have handed Resident #9 off to the OTR. The DOR stated normally when there were residents in therapy, if someone was going to step away, they handed off to another therapist. The DOR stated there had not been any incidents like that before or since Resident #9's fall and the staff was in-serviced on 12/16/24 on fall prevention and leaving residents unattended. The DOR stated they did in-services on ANE and fall prevention as often as needed through the facility and through the PT department and the last in-service was within the last month. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/26/25 at 2:32pm the COTA stated she was in the breakroom beginning lunch with the DOR and the OTR when she heard a thump, turned around and saw Resident #9 on the floor, went out of the breakroom to her and called out for the nurse to come see her. The COTA stated she had been in the gym but was focused on what she was doing so she did not know that Resident #9 was in the gym. The COTA stated the therapists normally went to get the resident at their allotted time and brought them to the gym for therapy. The COTA stated that hand off consisted of telling the person they were handing off to about the resident and making sure that the person receiving acknowledged the hand off. The COTA stated she saw the PTA while they were assessing the resident but did not know when he entered the gym. The COTA stated the PT staff was in-serviced that day (12/16/24) on hand off communication and fall prevention and their last ANE in-service was a few days ago on the computer through their on-line continuing education program. In an interview on 03/26/25 at 2:55pm the OTR stated she was on her lunchbreak in the breakroom part of the gym with the door open and heard a loud noise. The OTR stated the COTA who was sitting closest to the door looked out and said something like, oh no, so they all (the OTR, The COTA, and the DOR) got up and went out to the gym. The OTR stated she and the COTA stayed with Resident #9 who was awake and responding while the DOR went and got the nurse. When asked about the details of when the resident was brought to the therapy department, the OTR stated, I was sitting on a stool. The CNA walked in with the resident, asked who had her and the PTA said he had her. I said hi to her and was looking at her chair. When the PTA wheeled her over toward the parallel bars by the window, I went into the break room with the DOR and the COTA. There was no other staff in the gym with the PTA. The OTR stated they had never had an incident like that before and had not had one since. The OTR stated they were in-serviced by the regional person on proper hand offs and such and their las in-service on ANE was yesterday through their on-line continuing education program. The OTR stated. I feel like we do ANE and fall prevention in-services all the time. In a telephone interview on 03/26/25 at 3:18pm the PTA stated CNA E had put Resident #9 close to the doorway, so he moved her closer to the window and took off the leg rests from the wheelchair to get everything ready. The PTA stated, It was a miscommunication between me and my co-worker (the COTA). I thought she heard me say hey, can you watch my patient? I thought she said yes, but I guess she didn't hear me. I took my patient back to the dining room and when I got back, she (Resident #9) was on the floor. The PTA stated the COTA was in the lounge area, about 10 feet from the resident, not inside the lounge but facing it sitting sideways to Resident #9. The PTA stated the PT staff was in-serviced on 12/16/25 on proper hand off which meant in part to make sure that the resident was right next to the person taking hand off so that the resident could be properly supervised. The PTA stated he felt the reason Resident #9 fell was lack of communication and for sure lack of supervision and he had only seen her one time before and did not expect her to fall. The PTA stated the last in-service on ANE was last month. In an interview on 03/27/25 at 10:55am the DON stated as soon as she was informed that Resident #9 fell , she immediately went to give the resident a head-to-toe assessment. The DON stated Resident #9 had visible bruising and was sent to ER for further evaluation. The DON stated staff should have made sure the resident was visually handed off to another staff member so they could assume the care responsibilities and resident safety. The DON stated an in-service was conducted with all facility and rehabilitation staff on 12/16/24 about fall prevention and proper hand off of resident care as well as ANE. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 03/27/25 at 3:47pm the ADM stated, CNA E took Resident #9 to the gym and left her in the care of a therapist. That therapist took another resident out of the gym and he told another therapist to watch this resident. I think it was probably miscommunication. If someone is having to leave a resident for any reason, they should make sure that the person they are asking to help watch the resident hears them and understands what is being asked. If a resident, especially a fall risk resident, is left alone, they could fall which could lead to lacerations, broken bones, head injury, and/ or hospitalization . Staff was in serviced on effective communication about 2 months ago. It was not something that was regularly in-serviced, but it will be now, monthly. A supervision policy was requested from the facility on 03/26/25 but was not received. The facility's undated Fall Prevention Program policy reflected in part: A successful fall risk management program requires organizational commitment and an interdisciplinary team approach to prevent and minimize falls. This policy did not address supervision of fall risk residents.