STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455637	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Rehabilitation and Healthcare	1802 S 31st Temple, TX 76504

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have evidence that all alleged violations were thoroughly investigated and failed to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of four residents (Resident #1) reviewed for abuse and neglect. The facility failed to thoroughly investigate a fall in which Resident #1 sustained a femur (thigh bone) fracture on 06/10/2025 during a transfer by CNA B. This failure could place residents at risk of further abuse, physical harm, mental anguish and emotional distress. Findings include: Review of Resident #1's face sheet dated 06/16/2025 reflected an [AGE] year-old man admitted on [DATE] with discharge day of 06/10/2025 with diagnoses of vascular parkinsonism (disease that is caused by damage to blood vessels in the brain that leads to movement and balance problems that particularly affect the lower body), unspecified atrial fibrillation (irregular or rapid heartbeat), dysphagia (difficulty swallowing), need for assistance with personal care (need for help with activities of daily living), unsteadiness on feet (being unbalanced or unstable while standing or walking), other abnormalities of gait and mobility (abnormal walking pattern), weakness, unspecified intellectual disabilities, developmental disorder of scholastic skills, muscle weakness, and dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Review of Resident #1's BIMS assessment dated [DATE] reflected a score of 6 which indicated severe cognitive impairment. Review of Resident #1's MDS dated [DATE] reflected Resident #1 required substantial/ maximal assistance (helper does more than half the effort) for chair/bed-to-chair transfers. Further review reflected Resident #1 had no falls since the prior assessment or admission. Review reflected Resident #1 was 228 lbs and 74 inches tall. Record review of Resident #1's care plan, dated 05/31/2015, reflected the resident had impaired cognitive function with interventions to remember one/two step instructions. Review of Resident #1's care plan, dated 12/21/2021, reflected he had a self-care deficit and required substantial/maximal assist staff participation with transfers. Resident #1 was at risk for falls related to gait/balance problems. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of incident report dated 06/10/2025 at 5:00 AM reflected CNA B stated she helped Resident #1 get ready for the day and she tired to use stand and pivot method to transfer but while doing so Resident #1's leg slid, and she helped the resident slowly to the ground and Resident #1 tried to support himself with his knees. Resident #1 was transferred to the ER for evaluation and treatment. Review of progress note dated 06/10/2025 by LVN A reflected Resident #1 was assisted by CNA B when LVN A saw Resident #1 on the floor. LVN A completed an assessment and completed vitals. Review reflected Resident #1 was transferred to bed. Resident #1 was repositioned and had right hip tenderness noted with limited range of motion and pain level of 10/10. Resident #1 screamed when his right foot was moved but was calm when right leg was at rest. Resident #1's right thigh appeared to be swollen. Reached out to the on call provider and advised Resident #1 be sent to the hospital via EMS. There was no documentation of statements by CNA B or LVN A related to Resident #1's fall. No PIR was provided by the facility for Resident #1's fall. Review of hospital records dated 06/13/2025 reflected Resident #1 sustained a right femoral shaft fracture. Procedure performed was an open reduction and internal fixation of right femur shaft fracture with a cephalomedullary nail (surgically exposing fracture and realigning bone fragments and stabilizing the fracture with a nail inserted in the femur). During an interview on 06/13/2025 at 2:11 PM and 3:05 PM, CNA B stated she assisted Resident #1 with getting ready for the day on 06/10/2025. CNA B stated she attempted to transfer Resident #1 and she did not use a gait belt because the nurse did not tell her she needed to use one with Resident #1. CNA B stated she positioned Resident #1's wheelchair close to his bed and she was to the side and behind him. CNA B stated Resident #1 stood and then fell forward to his knees during the transfer. CNA B stated Resident #1 went straight down to the floor. CNA B stated Resident #1 usually stepped and then pivoted to the chair and he usually did most of the work. CNA B stated she usually stood behind Resident #1 for transfers and Resident #1 was the only resident she transferred from behind. CNA B stated she could find information on the Kardex (charting tool that provide care needs for a resident) for what the resident needed for assistance during transfers. CNA B stated her hands were on Resident #1's pants or back. CNA B stated she did not remember if she was on his left or right side, but stated she was behind him. CNA B stated Resident #1 sat on the edge of the bed and she usually told him to stand but that day (06/10/2025) he did not stand as usual and when she tried to help him, he felt like he was going down. CNA B stated Resident #1 fell forward after he lifted off the bed and he was standing and then went down with CNA B behind him. During an interview on 06/13/2025 at 3:27 PM, the DON stated she was out on 06/10/2025 and reviewed the progress note on 06/11/2025 about Resident #1's fall and stated initially she read CNA B helped Resident #1 slide down to the floor and she thought that's good she helped him. The DON stated CNA B stated she (CNA B) transferred Resident #1 and he slid down to the floor. The DON stated after the initial assessment Resident #1 was transferred to his bed and he started to scream and LVN A saw his leg was swollen and she reached out to the supervisor and on-call. The DON stated after she learned Resident #1 had a fracture she began re-education with staff on transfers. The DON stated she reviewed what each transfer was and proper transfer and body mechanics. The DON stated she did not ask CNA B if she had a gait belt and did not ask where CNA B was positioned during the transfer. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2025 at 3:40 PM, the ADM stated he expected staff to transfer residents correctly and there was zero tolerance for incorrect transfers. The ADM stated he was not aware of the specific details of Resident #1's transfer. The ADM stated he expected staff to use a gait belt 100 percent of the time when indicated. The ADM stated the IDT reviewed Resident #1's fall and discussed what could have been done better. The ADM stated he was not aware of the details regarding whether CNA B had a gait belt or where she was positioned when she transferred Resident #1 . The ADM stated he and the DON stressed to staff they should never be without supplies (including gait belts) and staff could call or text anytime they needed something. During an interview on 06/16/2025 at 1:37 PM, the ADM stated the IDT was responsible to review incident reports after falls after the morning meetings. The ADM stated incidents were determined to have a need for investigation on a case-by-case basis. The ADM stated any concerns related to an incident or falls were brought up then, he immediately started to talk with staff for more information. The ADM stated CNA B was interviewed on the specifics of the fall prior to 06/13/2025 but he was unsure who interviewed CNA B. The ADM stated he did not recall information regarding gait belt use or positioning of CNA B during the transfer being reported to the DON. The ADM stated an investigation included a focus on the root cause analysis and focus to prevent something to happen again to any residents. The ADM stated investigations were trigged by something the facility did not want to happen and how to prevent them from happening again. The ADM stated there was not a specific policy on investigating incidents and information was in the abuse policy. During an interview on 06/16/2025 at 1:46 PM, the DON stated LVN A stated CNA B reported Resident #1 slide down during the transfer. The DON stated she was out on 06/10/2025 and when she returned, she reviewed the notes and something did not add up. The DON stated after she talked to CNA B, she started to in-service the staff on body mechanics and transfers. The DON stated CNA B then reported she was behind Resident #1 during the transfer and the posture was not good. The DON stated CNA B did not mention the gait belt during the interview. The DON interviewed CNA B on 06/11/2025. The DON stated she and ADM discussed with the IDT about the fall and everyone felt something was off. During an interview on 06/16/2025 at 1:50 PM, the ADM and the DON stated they discussed with the IDT to be more vocal about any concerns and discussing an incident was more than just saying an incident or fall happened but needed to brainstorm why it happened and how to move forward. Record review of the facility's policy titled Abuse: Prevention of and Prohibition Against, with revision date of 04/2024, reflected an adverse event was an untoward, undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof. Investigation included that all identified events should be reported to the ADM immediately. Investigation would include interview with the residents, interviews with any witnesses to the incident, including the alleged perpetrator and review of staff members on all shifts who may have information regarding the alleged incident. At the conclusion, the facility with attempt to determine if abuse, neglect, misappropriation or exploitation has occurred. Further review reflected the results of the investigation would be documented.

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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** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1 was transferred safely, with a gait belt, correct positioning and with at least two staff, by CNA B when Resident #1 fell and sustained a femur (thigh bone) fracture which required surgery on 06/10/2025. An Immediate Jeopardy (IJ) was identified on 06/13/2025. While the IJ was removed on 06/15/2025, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the of the corrective systems . This failure could place residents at risk of unsafe transfers, falls, injuries, hospitalizations and/or death. Findings include: Record review of Resident #1's face sheet, dated 06/16/2025, reflected an [AGE] year-old man who was admitted to the facility on [DATE]. Resident #1 discharged on 06/10/2025. Resident #1 had with diagnoses which included vascular parkinsonism (disease that is caused by damage to blood vessels in the brain that leads to movement and balance problems that particularly affect the lower body), unspecified atrial fibrillation (irregular or rapid heartbeat), dysphagia (difficulty swallowing), need for assistance with personal care (need for help with activities of daily living), unsteadiness on feet (being unbalanced or unstable while standing or walking), other abnormalities of gait and mobility (abnormal walking pattern), weakness, unspecified intellectual disabilities, developmental disorder of scholastic skills, muscle weakness and dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Record review of Resident #1's fall risk evaluation, dated 02/04/2025, reflected Resident #1 was a high fall risk with no falls in the past three months. Resident #1 had balance problems while standing / walking. Record review of Resident #1's BIMS assessment, dated 02/22/2025, reflected a score of 6 which indicated severe cognitive impairment. Record review of Resident #1's MDS, dated [DATE], reflected Resident #1 required substantial/ maximal assistance (helper does more than half the effort, 2-staff requred) for chair/bed-to-chair transfers. Resident #1 had no falls since the prior assessment or admission. Resident #1 was 228 lbs and 74 inches tall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated 05/31/2015, reflected Resident #1 had impaired cognitive function with interventions to remember one/two step instructions. Review of Resident #1's care plan, dated 12/21/2021, reflected he had a self-care deficit and required substantial/maximal assist staff participation with transfers. Resident #1 was at risk for falls related to gait/balance problems. Review of care plan reflected no information regarding use of gait belt when transferring Resident #1. Review of Resident #1's chart reflected Kardex was unable to be reviewed due to Resident #1 being discharged from the facility. Record review of incident report, dated 06/10/2025 at 5:00 AM, reflected CNA B stated she helped Resident #1 get ready for the day and she tried to use the stand and pivot method to transfer but while doing so Resident #1's leg slid, and she helped the resident slowly to the ground and Resident #1 tried to support himself with his knees. Resident #1 was transferred to the ER for evaluation and treatment. Record review of progress note, dated 06/10/2025, by LVN A, reflected Resident #1 was assisted by CNA B when LVN A saw Resident #1 on the floor. LVN A completed an assessment and completed vitals. Resident #1 was transferred to bed. Resident #1 was repositioned and had right hip tenderness noted with limited range of motion and pain level of 10/10. Resident #1 screamed when his right foot was moved but was calm when the right leg was at rest. Resident #1's right thigh appeared to be swollen. Reached out to the on-call provider and advised Resident #1 be sent to the hospital via EMS. Record review of hospital records, dated 06/13/2025, reflected Resident #1 sustained a right femoral shaft fracture. Procedure performed was an open reduction and internal fixation of right femur shaft fracture with a cephalomedullary nail (surgically exposing fracture and realigning bone fragments and stabilizing the fracture with a nail inserted in the femur). During an interview on 06/13/2025 at 2:11 PM and 3:05 PM, CNA B stated she assisted Resident #1 with getting ready for the day on 06/10/2025. CNA B stated she attempted to transfer Resident #1 and she did not use a gait belt because the nurse did not tell her she needed to use one with Resident #1. CNA B stated she positioned Resident #1's wheelchair close to his bed and she was to the side and behind him. CNA B stated Resident #1 stood and then fell forward to his knees during the transfer. CNA B stated Resident #1 went straight down to the floor. CNA B stated Resident #1 usually stepped and then pivoted to the chair and he usually did most of the work. CNA B stated she usually stood behind Resident #1 for transfers and Resident #1 was the only resident she transferred from behind. CNA B stated she could find information on the Kardex (nursing tool for patient information) for what the resident needed for assistance during transfers. CNA B stated her hands were on Resident #1's pants or back. CNA B stated she did not remember if she was on his left or right side but stated she was behind him. CNA B stated Resident #1 sat on the edge of the bed and she usually told him to stand but that day (06/10/2025) he did not stand as usual and when she tried to help him, he felt like he was going down. CNA B stated Resident #1 fell forward after he lifted off the bed and he was standing and then went down with CNA B behind him. CNA B did not state if she checked the Kardex prior to the transfer . CNA B stated she usually got Resident #1 up for the day on her shift and he was usually able to stand and take a step and pivot . (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 06/13/2025 at 2:23 PM, CNA D stated staff could find transfer requirements on the Kardex. CNA D stated the Kardex told staff if a resident needed a 1 or 2 person transfer or minimum or maximum assistance. CNA D stated there was not a transfer that would occur where the CNA stood behind a resident. CNA D stated she stood in front of residents when she assisted them from bed to chair and chair to bed. CNA D stated gait belts should be used during transfers. During an interview on 06/13/2025 at 2:28 PM, the OT stated Resident #1's transfers fluctuated and sometimes Resident #1 needed more help, but it depended on the day . The OT stated Resident #1 was on therapy services because of the fluctuation in his transfers. The OT stated there were not one-person transfers in which the staff would stand behind a resident . The OT stated the staff would only stand behind the resident if there was another staff member present. The OT stated a gait belt should be used for all transfers for safety reasons. During an interview on 06/13/2025 at 2:48 PM, CNA E stated staff were supposed to always use a gait belt when they transferred a resident . CNA E stated staff was supposed to stand in front of residents during a transfer. CNA E stated unless there was another staff member then she would not be behind the residents. CNA E stated staff viewed the Kardex to show whether a resident needed a 1 or two person transfer or a mechanical lift. CNA E stated substantial / maximal assistance usually meant to bring another staff member with you. During an interview on 06/13/2025 at 2:51 PM, CNA C stated with a little muscle from the CNA Resident #1's wheelchair was positioned on the side of his bed at an angle with his bed rail in reach because Resident #1 utilized them to push up. CNA C stated Resident #1 needed guidance during the transfer and this included verbal cueing. CNA C stated a gait belt was required for every transfer with Resident #1. During an interview on 06/13/2025 at 3:31 PM, LVN F stated during a one-person transfer the staff would be facing the resident and be knee-to-knee or feet-to-feet. LVN F stated there were no transfers that occurred when a staff was behind the resident. LVN F stated a gait belt should be used at all time during a transfer. LVN F stated the purpose of a gait belt was to ensure you had a good grip on the resident and you did not have to grab the resident's clothing or skin. LVN F stated the risk of transferring a resident without a gait belt was losing balance or grip and a potential fall. LVN F stated it was important to have the correct positioning (being in front of the resident) during a transfer to prevent the resident from losing balance or the staff hurting themselves. (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 06/13/2025 at 3:27 PM, the DON stated during a transfer the first thing was for staff to use a gait belt. The DON stated staff were positioned in front of the resident with the staff's foot in between the resident's legs. The DON stated it was best practice to have a gait belt because staff never knew what could happen. The DON stated a resident who required maximum assistance definitely needed a gait belt to be used. The DON stated the purpose of a gait belt was for extra support or caution during transfers. The DON stated if staff transferred without a gait belt a lot of injuries could happen. The DON stated there were no transfers where a staff would be behind a resident and every single transfer had the staff in front of the resident. The DON stated if staff were behind a resident they could not see what they were doing. The DON stated staff were observed often and assessed for their transfer skills. The DON stated staff were assessed after hire and from time-to-time and if a concern was raised someone completed a transfer incorrectly. The DON stated after the aide transferred Resident #1 and fell, they started re-education of staff. The DON stated when incidents like that happened management wanted to educate so incidents were not repeated. The DON stated she expected staff to use a gait belt when indicated. The DON stated a gait belt would not be used for a resident who required only supervision and could transfer themselves or walk without assistance from staff, otherwise a gait belt was expected to be used. The DON stated most CNAs had a gait belt provided to them and after Resident #1 fell staff were informed a gait belt was a part of their uniform. The DON stated she expected staff to have proper positioning during transfers and if they were not sure they needed to ask questions. The DON stated the Kardex told the staff what a resident's transfer status was and how many staff were required. The DON stated staff were reminded to use the Kardex almost daily during the stand-down meeting. The DON stated she was out on 06/10/2025 and reviewed the progress note on 06/11/2025 about Resident #1's fall and stated initially she read the aide helped Resident #1 slide down to the floor and she thought that's good she helped him. The DON stated CNA B stated she (CNA B) transferred Resident #1 and he slid down to the floor. The DON stated after the initial assessment Resident #1 was transferred to his bed and he started to scream and LVN A saw his leg was swollen and she reached out to the supervisor and on-call. The DON stated after she learned Resident #1 had a fracture she began re-education with staff. The DON stated she reviewed what each transfer was and proper transfer and body mechanics. The DON stated she did not ask CNA B if she had a gait belt and did not ask where CNA B was positioned during the transfer. The DON stated she was only able to speak with LVN B. The DON stated Resident #1 had not had any falls prior to this incident. During an interview on 06/13/2025 at 3:40 PM, the ADM stated he expected staff to transfer residents correctly and there was zero tolerance for incorrect transfers. The ADM stated he was not aware of the specific details of Resident #1's transfer. The ADM stated he expected staff to use a gait belt 100 percent of the time when indicated. The ADM stated the IDT reviewed Resident #1's fall and discussed what could have been done better. The ADM stated he was not aware of the details regarding whether CNA B had a gait belt or where she was positioned when she transferred Resident #1. The ADM stated he and the DON stressed to staff they should never be without supplies (including gait belts) and staff could call or text anytime they needed something. During an interview on 06/13/2025 at 4:12 PM, the NP stated she expected staff to utilize safe transfer techniques. She stated Resident #1 did have intermittent confusion and other diagnoses that made him a fall risk. The NP stated not utilizing a gait belt or proper positioning during transfers could obviously result in a fall leading to a fracture. (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 06/23/2025 at 1:47 PM, the DON stated substantial/maximal assistance meant that two staff were required during the transfer. The DON stated when staff reported a resident had a change in level of assistance needed then care plans or Kardex was updated right away. The DON stated skills checks were observed upon hire. The DON stated she came to the building during off hours to check in with staff and observe care. The DON stated staff also had skills check three months after hire. The DON stated if staff expressed concerns or area where they needed more training during their new hire training their training would be extended. The DON stated if a resident required two people for their care then she expected two staff to provide that care. The DON stated the risk of not having another staff if a resident required two people for care was a fall that resulted in an injury. The DON stated staff were trained by a train the trainer method and new staff were paired with another staff and trained by the other staff through on the job training. The DON stated she checked in with staff at the end of their training to ask if they felt comfortable and if they needed any additional training in any area. The DON stated she or the ADON would complete the final skills check before staff were released to work independently . During an interview on 06/23/2025 at 3:45 PM, LVN A stated she was the charge nurse when Resident #1 fell. She stated it was considered a witnessed fall and from what she was told by CNA B, CNA B tried to transfer Resident #1, he missed a step and fell. LVN A stated she was not sure why CNA B transferred Resident #1 by herself. LVN A stated based on what the Kardex had and other the CNA said Resident #1 was a two-person transfer. LVN A stated substantial / maximal assistance was required a two people in the transfer. Record review of in-service, dated 06/11/2025, reflected substantial/maximal assistance required two people for transfers. Record review of in-service, dated 06/11/2025, with subject GGS (functional abilities and goals) reflected it reviewed types of assistance needed for transfer and staff required and reflected CNA B did not complete the in-service as of 06/13/2025. Record review of in-service, dated 06/11/2025, with subject Kardex reflected CNA B did not participate in the in-service as of 06/13/2025. The in-service included the purpose of Kardex and how it was used . Record review of in-service, dated 06/11/2025, with subject of body mechanics reflected CNA B did not participate in the in-service as of 06/13/2025. The in-service included body positioning during transfers . Record review of in-service, dated 06/11/2025, with topic safe resident transfers and handling reflected proper techniques, correct use of patient handing equipment and devices with the goal to ensure resident safety and reduce injury for both residents and staff. Review reflected CNA B completed this in-service as verified by signature and date of 06/11/2025. Record review of the facility's schedule / sign-in sheets for 06/11/2025 and 06/12/2025 reflected CNA B was not scheduled to work at the facility. Review of facility scheduled, dated 06/13/2025, reflected CNA B was scheduled to return to the facility from 10:00 pm - 6:00 am on 06/13/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Quality of Care Transfer of a Resident, Safe with revision, date of 05/2025, reflected use good body mechanics at all times .use a gait belt for all transfer if gait belts is indicated for the resident. The policy reflected for one-person transfers, apply gait belt around resident's waist, provide necessary assistance to help the resident stand up. The policy reflected two-person transfers using a gait belt required to apply the gait belt around the resident's wait, use good body mechanics at all times and provide the necessary help for the resident to stand up with caregivers on both sides of the resident and staff holding the gait belt. This was determined to be an Immediate Jeopardy (IJ) on 06/13/25 at 4:57 PM. The ADM and DON were notified . The ADM was provided with the IJ template on on 06/13/2025 at 4:57 PM. The following Plan of Removal submitted by the facility was accepted on 06/14/2025 at 4:01 PM : Immediate Plan of Removal The facility submits this Plan of Removal to address the Immediate Jeopardy identified, on 6/13/2025. Identification of Others Affected by Alleged Deficient Practice: All admissions and re-admissions have the potential to be affected by this alleged deficient practice. Summary: On 6/13/2025 an abbreviated survey was initiated at the facility. On 6/13/2025 the surveyor provided an Immediate Jeopardy (IJ) that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy (IJ) states as follows: F689 - The facility must ensure each resident receives adequate supervision and assistance devices to prevent accidents. The facility failed to ensure Resident #1 was transferred safely (with gait belt and correct positioning) by CNA B on 06/10/2025. Resident #1 is an [AGE] year-old man admitted on [DATE] with diagnoses of vascular parkinsonism, dysphagia, need for personal assistance with care, unsteadiness on feet, weakness, other abnormalities of gait and mobility, dementia, and muscle weakness. Resident has a BIMS of 6. Resident #1 sustained a fall on 06/10/2025 resulting in injury to right hip. CNA B reported that resident slid down to knees while helping resident get out of bed after personal care. Resident #1 was admitted to the hospital and underwent subsequent open reduction internal fixation of right hip fracture on 06/10/2025. CNA B reported to surveyor on 06/13/2025 that she did not utilize gait belt and was standing behind the resident during the transfer. Resident #1 returned to the facility on [DATE]. Action: Resident #1 was re-admitted on [DATE] at 6:53 PM, at the time of readmission-these assessments were completed: Initial admission assessment, pain assessment, fall risk assessment, skin assessment, elopement, Braden scale (assessment to evaluate a resident's risk for developing pressure ulcers), functional observation GG assessment (resident's functional goals and abilities), and initial care plan. (continued on next page)

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Wellington Rehabilitation and Healthcare	1802 S 31st Temple, TX 76504

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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	Start Date: 06/13/2025 Completion Date: 06/13/2025 Responsible: DON/Designee Action: Individual in-service with CNA B on transfer policy and understanding the Kardex. CNA B provided return demonstration competency on use of gait belt and a safe resident transfer. CNA B suspended effective 6.14.2025. Start Date: 06/13/2025 Completion Date: 06/14/2025 Responsible: Director of Nurses/Designee Action: Review of CNA B personnel file for skill competency for safe transfer. Competency check off for safe transfer completed upon hire on 04/09/2025. Start Date: 06/13/2025 Completion Date: 06/13/2025 Responsible: Director of Nursing (DON) Action: Thorough investigation of Resident #1 fall on 06/10/2025 conducted with root cause analysis identification of CNA B isolated error in performance of resident transfer. CNA B suspended effective 6.14. 2025. Start Date: 6/13/25 Completion Date: 6/14/25 Responsible: Executive Director, IDT, DON, Clinical Resource, MSN/Ed, RN Action: Medical Director and Nurse Practitioner notification of immediate jeopardy. Details of incident, root cause analysis, resident status, and plan of removal discussed. Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: Executive Director Action: Inservice Leadership Team, including but not limited to: Executive Director, Administrators in Training, Therapy Program Manager, Director of Nurses, Assistant Director of Nurses, and Staffing Coordinator on immediate jeopardy, details of incident, root cause analysis, resident status, plan of removal. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Inservice Leadership Team on the following: Fall assessment performed by nursing staff will include: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test Start Date: 06/13/2025 Completion Date: 06/13/2025 Responsible: Clinical Resource, MSN/Ed, RN Action: Audit 100% care plans of all active residents to confirm resident transfer status includes number of staff members required for safe transfer on the care plan and Kardex. No changes to care plans were indicated. All Kardex were up to date and current for resident transfer needs. Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: DON/Designee/Clinical Resource, MSN/Ed, RN Action: Inservice DON on the following: Fall assessment: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation. Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex. Understanding the Kardex: how to access Knowledge retention demonstrated with post-test Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: Clinical Resource, MSN/Ed, RN (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Action: Inservice 100% nursing and nursing leadership staff on the following: Fall assessment: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test Start Date: 6/13/25 Completion Date: 6/16/25 Responsible: DON/Designee Action: Inservice 100% CNA and therapy staff (including all PRN staff, new hires, and agency staff) on the following: Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test Start Date: 6/13/25 Completion Date: 6/16/25 Responsible: DON/Designee Action: Ad hoc QA meeting. Attendees will include ED , DON, Clinical Resource, Cluster Partners, Medical Director. Meeting will include the Plan of Removal and inventions. Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: Executive Director Systemic Change to Prevent Re-Occurrence: DON/Designee and IDT will ensure safe transfer requirements are assessed upon admission and added to the care plan and Kardex for all residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON/Designee and IDT will ensure safe transfer requirements are updated on the care plan and Kardex for any resident that has had a change in transfer status. Start Date: 6/13/25 Completion Date: Ongoing Monitoring of the POR from 06/14/2025 to 06/15/2025 included the following: During an interview with the ADM and the DON on 06/14/2025 at 10:29 AM, they stated Resident #1 returned to the facility on [DATE] at 6:49 PM. A telephone call was attempted to CNA B on 06/14/2025 at 3:08 PM with message requesting for call back. No message was returned by CNA B . During an interview with the ADM and the DON on 06/14/2025 at 10:29 AM, it was stated CNA received in-service and skills check off prior to her shift on 06/13/2025. CNA B was suspended at 2:00 PM on 06/14/2025 after the ADM and DON decided to suspend CNA B until a formal corrective action plan could be developed and implemented . Observation and interview with Resident #1 on 06/14/2025 at 1:15 PM revealed Resident #1 laid in bed with the call light in reach. Resident #1 responded to simple questions with garbled speech. Resident #1 denied any pain and that it was controlled . During interviews conducted from 06/14/2025 to 06/15/2025 with 6 CNAs, 2 LVNs, ADM, DON and 2 AITs reflected staff received in-service either on 06/14/2025 or 06/15/2025 prior to their shifts. Interviewed staff stated they were trained on how to safely transfer a resident from bed-to-chair/chair-to-bed, how to access the Kardex to review transfer status of a resident , use of gait belts (required to have as part of uniform) and to use when indicated when transferring a resident. Interviewed staff stated they took a posttest and demonstrated skills check off on transfers. During an interview on 06/15/2025 at 11:53 AM, the ADM stated the Medical Director and Nurse Practitioner were notified of the IJ. Review of phone logs reflected MD was contacted at 6:05 PM on 6/13/2025 and NP was contacted on 06/13/2025 at 5:45 PM. During an interview on 06/15/2025 at 11:57 AM, the ADM and the DON, stated they were at 90% completion of staff in-servicing. The ADM stated they had reached out to all staff who had not received the in-service and staff were not allowed to work until the training was completed. Review of the spread sheet of in-serviced staff reflected almost all staff were in-serviced as of 06/15/2025. During an interview on 06/15/2025 at 11:56 AM, the DON stated the audit was completed and no changes were identified during the audit. Record review of in-service sign-in sheets, dated 06/13/2025, reflected CNA B participated in the in-service on transfer policy and understanding the Kardex. CNA B provided return demonstration competency on use of gait belt and safe resident transfer and knowledge demonstrated via post-test, dated 06/13/2025. Review of CNA B's employee file reflected a skills competency was completed on 04/09/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of counseling/disciplinary notice, dated 06/14/2025, reflected CNA B was suspended pending investigation and CNA B was informed via phone call. Record review of the QAPI meeting sign in sheet and agenda, dated 06/13/2025, reflected MD and NP were notified and meeting was held. Record review of root cause analysis, dated 06/13/2025, reflected the incident with CNA B was an isolated incident after she transferred Resident #1 alone and without a gait belt. CNA B was suspended on 06/14/2025. Record review of care plan resident roster audit documentation, dated 06/13/2025, reflected all resident's charts were audited and Kardex and care plan were updated as needed. Record review of in-service sign-in, dated 06/13/2025, reflected transfer policy and procedure was reviewed, understanding the Kardex, fall management was completed with DON by clinical resource. Record review of in-service sign-in sheets, dated 06/13/2025, reflected transfer policy and procedure was reviewed and understanding the Kardex reflected 19 staff participated. Record review of in-service sign-in sheet, dated 06/13/2025, reflected fall management in-service was completed with 6 nurses and 1 ADON. Record review of in-service sign-in sheet, dated 06/13/2025, reflected IJ, details of incident, root cause analysis, resident status and plan of removal was completed with ADM, 2 AITs , ADON and DON by clinical resource. Record review of 11 post-tests and 11 skills check-offs sheets, dated 06/13/2025, reflected staff demonstrated proper transfer skills and returned demonstration of knowledge from in-services. Record review of Resident #1's fall assessment, dated 06/13/2025, reflected Resident #1 was a high risk for falls and regularly incontinent. Record review of Resident #1's pain assessment, dated 06/13/2025, reflected Resident #1 had a dull pain and rated 4/10 at incision site. Record review of Resident #1's re-admission asking assessment reflected Resident #1 had outer right knee had 2 intact sutures, lateral right thigh had 2 intact sutures and right trochanter had 3 intact sutures. Review of Resident #1 elopement assessment, dated 06/13/2025, reflected Resident #1 was a low risk for elopement. Record review of Resident #1's Braden scale assessment, dated 06/13/2025, reflected the resident was a moderate risk for developing pressure sores. Record review of Resident #1's Kardex, dated 06/14/2025, reflected Resident #1 required substantial / maximal assistance staff participation with transfers . (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 informed the Immediate Jeopardy was removed on 06/15/2025 at 4:00 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place .

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that nurse aides were able to demonstrate competency in skill and techniques necessary to care for resident's needs, as identified through resident assessments, and described in the plan of care for 1 of 4 (Resident #1) related to safe transfers. The facility failed to ensure CNA B used the accurate technique to transfer Resident #1 safely (with gait belt, correct positioning and/or two-people) on 06/10/2025. An Immediate Jeopardy (IJ) situation was identified on 06/23/2025. While the IJ was removed on 06/24/2025, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems . This failure could place residents at risk of avoidable falls, injuries, hospitalization and/or death. Findings include: Review of Resident #1's face sheet dated 06/16/2025 reflected an [AGE] year-old man admitted on [DATE] with discharge day of 06/10/2025 with diagnoses of vascular parkinsonism (disease that is caused by damage to blood vessels in the brain that leads to movement and balance problems that particularly affect the lower body), unspecified atrial fibrillation (irregular or rapid heartbeat), dysphagia (difficulty swallowing), need for assistance with personal care (need for help with activities of daily living), unsteadiness on feet (being unbalanced or unstable while standing or walking), other abnormalities of gait and mobility (abnormal walking pattern), weakness, unspecified intellectual disabilities, developmental disorder of scholastic skills, muscle weakness, and dementia (loss of memory, language, problem-solving and other thinking abilities that interfere with daily life). Review of Resident #1's fall risk evaluation dated 02/04/2025 reflected Resident #1 was a high fall risk with no falls in the past three months. Resident #1 had balance problems while standing / walking. Review of Resident #1's BIMS assessment dated [DATE] reflected a score of 6 which indicated severe cognitive impairment. Review of Resident #1's MDS dated [DATE] reflected Resident #1 required substantial/ maximal assistance (helper does more than half the effort) for chair/bed-to-chair transfers. Further review reflected Resident #1 had no falls since the prior assessment or admission. Review reflected Resident #1 was 228 lbs and 74 inches tall. Review of Resident #1's care plan dated 05/31/2015 reflected Resident had impaired cognitive function with interventions to remember one/two step instructions. Review of Resident #1's care plan dated 12/21/2021 reflected he had a self-care deficit and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	required substantial/maximal assist staff participation with transfers. Further review reflected Resident #1 was at risk for falls related to gait/balance problems. Review of care plan reflected no information regarding use of gait belt when transferring Resident #1. Review of incident report dated 06/10/2025 at 5:00 AM reflected CNA B stated she helped Resident #1 get ready for the day and she tired to use stand and pivot method to transfer but while doing so Resident #1's leg slid, and she helped the resident slowly to the ground and Resident #1 tried to support himself with his knees. Resident #1 was transferred to the ER for evaluation and treatment. Review of progress note dated 06/10/2025 by LVN A reflected Resident #1 was assisted by CNA B when LVN A saw Resident #1 on the floor. LVN A completed an assessment and completed vitals. Review reflected Resident #1 was transferred to bed. Resident #1 was repositioned and had right hip tenderness noted with limited range of motion and pain level of 10/10. Resident #1 screamed when his right foot was moved but was calm when right leg was at rest. Resident #1's right thigh appeared to be swollen. Reached out to the on call provider and advised Resident #1 be sent to the hospital via EMS. Review of hospital records dated 06/13/2025 reflected Resident #1 sustained a right femoral shaft fracture. Procedure performed was an open reduction and internal fixation of right femur shaft fracture with a cephalomedullary nail (surgically exposing fracture and realigning bone fragments and stabilizing the fracture with a nail inserted in the femur). During an interview on 06/13/2025 at 2:11 PM and 3:05 PM, CNA B stated that she assisted Resident #1 with getting ready for the day on 06/10/2025. CNA B stated that she attempted to transfer Resident #1 and that she did not use a gait belt because the nurse did not tell her she needed to use one with Resident #1. CNA B stated she positioned Resident #1's wheelchair close to his bed and she was to the side and behind him. CNA B stated Resident #1 stood and then fell forward to his knees during the transfer. CNA B stated that Resident #1 went straight down to the floor. CNA B stated that Resident #1 usually stepped and then pivoted to the chair and he usually did most of the work. CNA B stated she usually stood behind Resident #1 for transfers and Resident #1 was the only resident she transferred from behind. CNA B stated that she could find information on the Kardex (nursing tool for patient information) for what the resident needed for assistance during transfers. CNA B stated that her hands were on Resident #1's pants or back. CNA B stated she did not remember if she was on his left or right side but stated she was behind him. CNA B stated Resident #1 sat on the edge of the bed and she usually told him to stand but that day (06/10/2025) he did not stand as usual and when she tried to help him he felt like he was going down. CNA B stated that Resident #1 fell forward after he lifted off the bed and he was standing and then went down with CNA B behind him. CNA B did not state if she checked the Kardex prior to the transfer. CNA B stated she usually got Resident #1 up for the day on her shift and he was usually able to stand and take a step and pivot. During an interview on 06/13/2025 at 2:23 PM, CNA D stated that staff could find transfer requirements on Kardex. CNA D stated that the Kardex told staff if a resident needed a 1 or 2 person transfer or minimum or maximum assistance. CNA D stated that there was not a transfer that would occur where the CNA stood behind a resident. CNA D stated that she stood in front of residents when she assisted them from bed to chair and chair to bed. CNA D stated gait belts should be used during transfers. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/13/2025 at 2:28 PM, the OT stated that Resident #1's transfers fluctuated and sometimes Resident #1 needed more help, but it depended on the day. The OT stated that Resident #1 was on therapy service because of the fluctuation in his transfers. The OT stated that there were not one-person transfers in which the staff would stand behind a resident. The OT stated that the staff would only stand behind the resident if there was another staff member present. The OT stated that a gait belt should be used for all transfers for safety reasons. During an interview on 06/13/2025 at 2:48 PM, CNA E stated that staff were supposed to always use a gait belt when they transferred a resident. CNA E stated staff was supposed to stand in front of residents during a transfer. CNA E stated unless there was another staff member then she would not be behind the residents. CNA E stated that staff viewed the Kardex to show whether a resident needed a 1 or two person transfer or a mechanical lift. CNA E stated substantial / maximal assistance usually meant to bring another staff member with you. During an interview on 06/13/2025 at 2:51 PM, CNA C stated with a little muscle from the CNA Resident #1's wheelchair was positioned on the side of his bed at an angle with his bed rail in reach because Resident #1 utilized them to push up. CNA C stated that Resident #1 needed guidance during the transfer and this included verbal cueing. CNA C stated that a gait belt was required for every transfer with Resident #1. During an interview on 06/13/2025 at 3:31 PM, LVN F stated that during a one-person transfer the staff would be facing the resident and be knee-to-knee or feet-to-feet. LVN F stated that there were no transfers that occurred when a staff was behind the resident. LVN F stated a gait belt should be used at all times during a transfer. LVN F stated the purpose of a gait belt was to ensure you had a good grip on the resident and you did not have to grab the resident's clothing or skin. LVN F stated the risk of transferring a resident without a gait belt was losing balance or grip and a potential fall. LVN F stated it was important to have the correct positioning (being in front of the resident) during a transfer to prevent the resident from losing balance or the staff hurting themselves. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/13/2025 at 3:27 PM, the DON stated that during a transfer that first thing was for staff to use a gait belt. The DON stated that staff were positioned in front of the resident with the staff's foot in between the resident's legs. The DON stated that it was best practice to have a gait belt because staff never knew what could happen. The DON stated that a resident that required maximum assistance definitely needed a gait belt to be used. The DON stated the purpose of a gait belt was for extra support or caution during transfers. The DON stated if staff transferred without a gait belt a lot of injuries could happen. The DON stated there were no transfers that a staff would be behind a resident and every single transfer had the staff in front of the resident. The DON stated if staff were behind a resident they could not see what they were doing. The DON stated staff were observed often and assessed for their transfer skills. The DON stated staff were assessed after hire and from time-to-time and if a concern was raised that someone completed a transfer incorrectly. The DON stated after the aide transferred Resident #1 and fell, they started re-education of staff. The DON stated that when incidents like that happened management wanted to educate so incidents were not repeated. The DON stated that she expected staff to use a gait belt when indicated. The DON stated a gait belt would not be used for a resident who required only supervision and could transfer themselves or walk without assistance from staff, otherwise a gait belt was expected to be used. The DON stated that most CNAs had a gait belt provided to them and after Resident #1 fell staff were informed a gait belt was a part of their uniform. The DON stated that she expected staff to have proper positioning during transfers and that if they were not sure they needed to ask questions. The DON stated the Kardex told the staff what a resident's transfer status was and how many staff were required. The DON stated that staff were reminded to use the Kardex almost daily during the stand-down meeting. The DON stated that she was out on 06/10/2025 and reviewed the progress note on 06/11/2025 about Resident #1's fall and stated that initially she read the aide helped Resident #1 slide down to the floor and she thought that's good she helped him. The DON stated that CNA B stated she (CNA B) transferred Resident #1 and he slid down to the floor. The DON stated that after the initial assessment Resident #1 was transferred to his bed and he started to scream and LVN A saw that his leg was swollen and she reached out to the supervisor and on-call. The DON stated that after she learned Resident #1 had a fracture she began re-education with staff. The DON stated she reviewed what each transfer was and proper transfer and body mechanics. The DON stated she did not ask CNA B if she had a gait belt and did not ask where CNA B was positioned during the transfer. The DON stated she was only able to speak with LVN B. The DON stated that Resident #1 had not had any falls prior to this incident. During an interview on 06/13/2025 at 3:40 PM the ADM stated that he expected staff to transfer residents correctly and there was zero tolerance for incorrect transfers. The ADM stated he was not aware of the specific details of Resident #1's transfer. The ADM stated he expected staff to use a gait belt 100 percent of the time when indicated. The ADM stated the IDT reviewed Resident #1's fall and discussed what could have been done better. The ADM stated he was not aware of the details regarding whether CNA B had a gait belt or where she was positioned when she transferred Resident #1. The ADM stated that he and the DON stressed to staff that they should never be without supplies (including gait belts) and staff could call or text anytime they needed something. During an interview on 06/13/2025 at 4:12 PM, the NP stated that she expected staff to utilize safe transfer techniques. She stated Resident #1 did have intermittent confusion and other diagnoses that made him a fall risk. NP stated not utilizing a gait belt or proper positioning during transfers could obviously result in a fall leading to a fracture. (continued on next page)

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Wellington Rehabilitation and Healthcare	1802 S 31st Temple, TX 76504

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/23/2025 at 1:47 PM, the DON stated substantial/maximal assistance meant that two staff were required during the transfer. The DON stated when staff reported a resident had a change in level of assistance needed then care plans or Kardex was updated right away. The DON stated skills checks were observed upon hire. The DON stated she came to the building during off hours to check in with staff and observe care. The DON stated staff also had skills check three months after hire. The DON stated if staff expressed concerns or area where they needed more training during their new hire training their training would be extended. The DON stated if a resident required two people for their care then she expected two staff to provide that care. The DON stated the risk of not having another staff if a resident required two people for care was a fall that resulted in an injury. The DON stated staff were trained by a train the trainer method and new staff were paired with another staff and trained by the other staff through on the job training. The DON stated she checked in with staff at the end of their training to ask if they felt comfortable and if they needed any additional training in any area. The DON stated she or the ADON would complete the final skills check before staff were released to work independently . During an interview on 06/23/2025 at 3:45 PM, LVN A stated she was the charge nurse when Resident #1 fell. She stated it was considered a witnessed fall and from what she was told by CNA B, CNA B tried to transfer Resident #1, he missed a step and fell. LVN A stated she was not sure why CNA B transferred Resident #1 by herself. LVN A stated based on what the Kardex had and other the CNA said Resident #1 was a two-person transfer. LVN A stated substantial / maximal assistance was required a two people in the transfer. Record review of CNA B's employee file reflected skills check off was completed for CNA B on 01/10/2025 and 04/09/2025 and included one-person, two-person and hoyer transfers. Record review of in-service, dated 06/11/2025, with subject GGS (functional abilities and goals) reflected it reviewed types of assistance needed for transfer, staff required and reflected CNA B did not complete the in-service as of 06/13/2025. Record review of in-service, dated 06/11/2025, with subject Kardex reflected CNA B did not participate in the in-service as of 06/13/2025. The in-service included the purpose of Kardex and how it was used. Record review of in-service, dated 06/11/2025, with subject of body mechanics reflected CNA B did not participate in the in-service as of 06/13/2025. The in-service included body positioning during transfers. Record review of in-service, dated 06/11/2025, reflected substantial/maximal assistance required two people for transfers. Record review of in-service, dated 06/11/2025, with topic safe resident transfers and handling reflected proper techniques, correct use of patient handing equipment and devices with the goal to ensure resident safety and reduce injury for both residents and staff. Review reflected CNA B completed this in-service as verified by signature and date of 06/11/2025. Record review of the facility's schedule / sign-in sheets for 06/11/2025, 06/12/2025 reflected CNA B was not scheduled to work at the facility. Review of the facility schedule dated 06/13/2025 reflected CNA B was scheduled to return to the facility from 10:00 pm - 6:00 am on 06/13/2025. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy titled Quality of Care Transfer of a Resident, Safe with revision date of 05/2025 reflected use good body mechanics at all times and use a gait belt for all transfer if gait belts is indicated for the resident. The policy reflected for one-person transfers, apply gait belt around resident's waist, provide necessary assistance to help the resident stand up. The policy reflected two-person transfers using a gait belt required to apply the gait belt around the resident's wait, use good body mechanics at all times and provide the necessary help f or the resident to stand up with caregivers on both sides of the resident and staff holding the gait belt. This was determined to be an Immediate Jeopardy (IJ) on 06/23/2025. The ADM and DON were notified on 06/23/2025 at 3:45 PM and a template was given. The following Plan of Removal submitted by the facility was accepted on 06/24/2025 at 7:48 AM: Immediate Plan of Removal The facility submits this Plan of Removal to address the Immediate Jeopardy identified, on 6/23/2025. Identification of Others Affected by Alleged Deficient Practice: All admissions and re-admissions have the potential to be affected by this alleged deficient practice. Summary: On 6/13/2025 an abbreviated survey was initiated at the facility. On 6/13/2025 the surveyor provided an Immediate Jeopardy (IJ) that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. On 6/23/2025 after review by enforcement, an additional Immediate Jeopardy (IJ) has been cited. The notification of Immediate Jeopardy (IJ) states as follows: F726 - The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. The facility failed to ensure CNA B used the accurate technique to transfer Resident #1 safely (with gait belt, correct positioning and/or two-people) on 06/10/2025. Resident #1 is an [AGE] year-old man admitted on [DATE] with diagnoses of vascular parkinsonism, dysphagia, need for personal assistance with care, unsteadiness on feet, weakness, other abnormalities of gait and mobility, dementia, and muscle weakness. Resident has a BIMS of 6. Resident #1 sustained a fall on 06/10/2025 resulting in injury to right hip. CNA B reported that resident slid down to knees while helping resident get out of bed after personal care. Resident #1 was admitted to the hospital and underwent subsequent open reduction internal fixation of right hip fracture on 06/10/2025. CNA B reported to surveyor on 06/13/2025 that she did not utilize gait belt and was standing behind the resident during the transfer. Resident #1 returned to the facility on [DATE]. Action: Resident #1 was re-admitted on [DATE] at 18:53 PM , at the time of readmission-these assessments were completed: Initial admission assessment, pain assessment, fall risk assessment, skin assessment, elopement, Braden scale, functional observation GG assessment, and initial care plan (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 06/13/2025 Completion Date: 06/13/2025 Responsible: DON/Designee Action: Individual in-service with CNA B on transfer policy and understanding the Kardex. CNA B provided return demonstration competency on use of gait belt and a safe resident transfer. CNA B suspended effective 6.14.2025 and subsequently terminated on 6.18.2025. Start Date: 06/13/2025 Completion Date: 06/18/2025 Responsible: Director of Nurses/Designee Start Date: 6/13/25 Completion Date: 6/14/25 Responsible: Executive Director, IDT, DON, Clinical Resource, MSN/Ed, RN Action: Medical Director and Nurse Practitioner notification of immediate jeopardy. Details of incident, root cause analysis, resident status, and plan of removal discussed. Start Date: 6/13/25 and 6/23/25 Completion Date: 6/13/25 and 6/23/25 Responsible: Executive Director Action: Inservice Leadership Team, including but not limited to: Executive Director, Administrators in Training, Therapy Program Manager, Director of Nurses, Assistant Director of Nurses, and Staffing Coordinator on immediate jeopardy, details of incident, root cause analysis, resident status, plan of removal. Inservice Leadership Team on the following: Fall assessment performed by nursing staff will include: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 06/13/2025 Completion Date: 06/13/2025 Responsible: Clinical Resource, MSN/Ed, RN Action: Audit 100% care plans of all active residents to confirm resident transfer status includes number of staff members required for safe transfer on the care plan and Kardex. No changes to care plans were indicated. All Kardex were up to date and current for resident transfer needs. Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: DON/Designee/Clinical Resource, MSN/Ed, RN Action: Inservice DON on the following: Fall assessment: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: Clinical Resource, MSN/Ed, RN Action: Inservice 100% nursing and nursing leadership staff on the following: Fall assessment: completion of SBAR, not moving resident if injury suspected, activation of 911, provider notification, DON notification, representative notification, change of condition completion, progress note documentation Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test and return demonstration (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 6/13/25 Completion Date: 6/16/25 Responsible: DON/Designee Action: Inservice 100% CNA and therapy staff (including all PRN staff, new hires, and agency staff) on the following: Transfer policy, use of gait belt, safety with transfers, identification of resident transfer requirements through use of Kardex Understanding the Kardex: how to access Knowledge retention demonstrated with post-test and return demonstration Start Date: 6/13/25 Completion Date: 6/16/25 Responsible: DON/Designee Action: Ad hoc QA meeting. Attendees will include ED , DON, Clinical Resource, Cluster Partners, Medical Director. Meeting will include the Plan of Removal and inventions. Start Date: 6/13/25 Completion Date: 6/13/25 Responsible: Executive Director Action: Ad hoc QA meeting. Attendees will include ED, DON, Clinical Resource, Cluster Partners, Medical Director. Meeting will include the Plan of Removal and interventions. Start Date: 6/23/25 Completion Date: 6/23/25 Responsible: Executive Director Systemic Change to Prevent Re-Occurrence: DON/Designee and IDT will ensure safe transfer requirements are assessed upon admission and added to the care plan and Kardex for all residents. DON/Designee and IDT will ensure safe transfer requirements are updated on the care plan and Kardex for any resident that has had a change in transfer status. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 6/13/25 Completion Date: Ongoing Monitoring of the POR on 06/24/2025 included the following: A telephone call was attempted to CNA B on 06/14/2025 at 3:08 PM with message requesting for call back. No message was returned by CNA B . During an interview with the ADM and the DON on 06/14/2025 at 10:29 AM, it was stated CNA received in-service and skills check off prior to her shift on 06/13/2025. CNA B was suspended at 2:00 PM on 06/14/2025 after ADM and DON decided to suspend CNA B until a formal corrective action plan could be developed and implemented. During an interview on 06/15/2025 at 11:56 AM, the DON stated the audit was completed and no changes were identified during the audit. Observation and interview with Resident #1 on 06/14/2025 at 1:15 PM revealed Resident #1 laid in bed with call light in reach. Resident #1 responded to simple questions with garbled speech. Resident #1 denied any pain and that it was controlled. During an interview on 06/24/2025 at 12:59 PM, the ADM stated he was not able to get ahold of the 3 suspended staff to in-service them . The ADM stated they were not on the floor until they got the in-service. The ADM stated he had not been able to contact the staff to terminate them. During interviews conducted from 06/14/2025 - 06/15/2025 and on 06/23/2025 with 8 CNAs, 3 LVNs, ADM, DON and 2 AITs reflected staff received in-services either 06/14/2025 or 06/15/2025 prior to their shifts. Interviewed staff stated they were trained on how to safely transfer a resident from bed-to-chair/chair-to-bed, how to access the Kardex to review transfer status of a resident, use of gait belts (required to have as part of uniform) and to use when indicated when transferring a resident . Interviewed staff stated they took a posttest and demonstrated skills check off on transfers. During interviews with staff in-training on 06/24/2025, 3 CNAs stated they were currently in-training. CNAs stated they started at the facility between 06/19/2025 and 06/21/2025. CNAs stated they received in-services on using the Kardex, levels of transfer status and how many staff are involved in each transfer and to use a gait belt for each transfer . Interviewed staff were able to stated a gait belt should be used for each transfer, that staff should stand in front of the resident for transfers (except for mechanical lift transfers) and the Kardex was where to find how many staff were needed for a transfer, how much assistance was needed for a transfer and if a resident required a mechanical lift for a transfer. Staff stated they received the in-service after they started, but before they started their shift working on the floor at the facility over the phone and again in-person. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DON on 06/24/2025 at 12:37 PM, the DON stated when a new admission arrived an initial assessment was conducted by the nurse or therapy to determine transfer status. The DON stated the nurse completed the assessment until therapy was able to come in and assess the resident. The DON stated periodically information was gathered by staff when they observed a change in a resident's care needs or abilities to participate in transfer during care. The DON stated if a staff reported a resident required more help, transfer status was changed to reflect assistance needed immediately in the Kardex. During an interview with the ADM on 06/24/2025 at 12:50 PM, the IDT was responsible to ensure transfer needs were updated in the Kardex for any changes and new admission . The ADM stated leadership staff were responsible to train any new hires on transfer required and the Kardex. Record review of in-service sign-in sheets, dated 06/13/2025, reflected CNA B participated in the in-service on transfer policy and understanding the Kardex. CNA B provided return demonstration competency on use of gait belt and safe resident transfer and knowledge demonstrated via post-test, dated 06/13/2025. Review of CNA B's employee file reflected a skills competency was completed on 04/09/2025. Record review of counseling/disciplinary notice, dated 06/14/2025, reflected CNA B was suspended pending investigation and CNA B was informed via phone call. Record review of the QAPI meeting sign in sheet and agenda, dated 06/23/2025, reflected MD and NP were notified and meeting was held. Record review of text message from ADM to MD and NP, dated 06/23/2025, reflected MD and NP were notified of IJ. Record review of root cause analysis, dated 06/13/2025, reflected the incident with CNA B was an isolated incident after she transferred Resident #1 alone and without a gait belt. CNA B was suspended on 06/14/2025. Record review of care plan resident roster audit documentation, dated 06/13/2025, reflected all resident's charts were audited and Kardex and care plan were updated as needed. Record review of in-service sign-in, dated 06/13/2025, reflected transfer policy and procedure was reviewed, understanding the Kardex, fall management was completed with DON by clinical resource. Record review of in-service sign-in sheets, dated 06/13/2025, reflected transfer policy and procedure was reviewed and understanding the Kardex reflected 19 staff participated. Record review of in-service sign-in sheet, dated 06/13/2025, reflected fall management in-service was completed with 6 nurses and 1 ADON. Record review of in-service sign-in sheet, dated 06/13/2025, reflected IJ, details of incident, root cause analysis, resident status and plan of removal was completed with ADM, 2 AITs , ADON, and DON by clinical resource. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of 11 post-tests and 11 skills check-offs sheets, dated 06/13/2025, reflected staff demonstrated proper transfer skills and returned demonstration of knowledge from in-services. Record review of Resident #1's fall assessment, dated 06/13/2025, reflected Resident #1 was a high risk for falls and regularly incontinent. Record review of Resident #1's pain assessment, dated 06/13/2025, reflected Resident #1 had a dull pain and rated 4/10 at incision site. Record review of Resident #1's re-admission asking assessment reflected Resident #1 had outer right knee had 2 intact sutures, lateral right thigh had 2 intact sutures and right trochanter had 3 intact sutures. Review of Resident #1 elopement assessment dated [DATE] reflected Resident #1 was a low risk for elopement. Record review of Resident #1's Braden scale assessment, dated 06/13/2025, reflected resident was a moderate risk for developing pressure sores. Record review of Resident #1's kardex, dated 06/24/2025, reflected Resident #1 required mechanical lift transfer with 2 person assistance . Record review of Resident #1's care plan and 5 other resident care plans reflected transfer status included