STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17141 Based on record review, observations and interviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the residents' rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #1) experiencing falls. The facility failed to include frequent falls as a focus area to provide possible preventive interventions despite the resident having serious injuries from falls in his recent history, prior to admission and multiple falls since his admission. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 06/01/24 at 6:03PM and the facility was notified and given an IJ template. While the IJ was removed on 06/04/24 at 4:00 PM, the facility remained out of compliance at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice placed residents at an increased risk for falls, injury, or death, due to an interdisciplinary team not having included interventions in the care plan developed specifically to meet the needs of each resident. Findings include: Review of Resident #1's Face sheet, undated, revealed he was admitted to the facility on [DATE] from a local hospital. Resident #1's admitting diagnoses included traumatic subdural hemorrhage (brain injury resulting in a bleed from a vessel causing blood to collect between the brain and skull), epileptic seizures, fracture of skull and facial bones, unspecified fall. Review of Resident #1's Local Hospital Discharge Summary dated 4/29/24 revealed Resident #1 had been admitted on [DATE] with a problem list of 1.Fall with Injury (Acute, Onset:3/13/24) 2. Intercranial subdural hemorrhage (Acute, Onset:03/13/24) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	discharge date [DATE] Discharge diagnosis: Found down with TBI Pt condition on discharge: stable. Review of Resident #1's 5-day MDS assessment, dated 5/3/24 revealed a BIMs score of 10 indicating moderate cognitive impairment. In section J for the question asking has the resident had a fall in the last month prior to admission/entry or reentry the answer is yes. For any falls since Admission/entry or reentry or prior assessment the answer is no. (Resident #1 had falls on 5/1 and 5/2.). Review of Resident #1's Admission MDS assessment, dated 5/3/24 revealed a BIMs score of 10 indicating moderate cognitive impairment. Section GG notes Resident #1 is dependent on staff helper does all the effort to walk ten feet. In section J for the question asking has the resident had a fall in the last month prior to admission/entry or reentry the answer is No . For any falls since Admission/entry or reentry or prior assessment the answer is no. (Resident #1 had falls on 5/1 and 5/2.) Review of Resident #1's Care Plan revealed falls are not included in the areas addressed. The only area addressed with a goal and interventions is elopement initiated on 4/29/24. Another focus area listed was the resident requires antidepressant medication. There are instructions to include the medication and the diagnosis, however, neither are included. There are no goals and no interventions. The focus area was initiated 5/1/24. The third and final focus area states the resident has impaired cognitive function/dementia or impaired thought processes. The goal is the resident will maintain his current level of cognitive functioning. No interventions are listed. Review of Resident #1's Care Plan Conference, dated 5/6/2024 revealed that other than the resident's name and date the form is blank . Review of Resident #1's Nursing Progress Notes reveals falls documented on 5/1/24, 5/2/24, 5/4/24, 5/5/24, 5/10/24, 5/15/24, and 5/30/24. The fall on 5/1/24 required a trip to the hospital for a CT scan after Resident #1 complained of hitting his head. The fall on 5/30/24 required overnight hospitalization after the facility nurse found Resident #1 on the floor in his bathroom with a knot to the back of his head. Observations and interview on 6/1/24 at 9:40 AM of Resident #1's room revealed he was sitting in the room attempting to put on his shoes. Resident #1's bed was noted to be neatly made with the call light attached to the top cover of the bed which was at a normal bed height. A fall mat was noted to be folded against the wall on the opposite side of the room near an empty bed. When asked what the call light was for Resident #1 was unsure. When asked if he could use it to call for help such as when going to the bathroom, Resident #1 denied that he needed help and began to stand from his wheelchair. Resident #1 was able to read a sign on his wall that said his family did his laundry but there were no other signs in the room including any to prompt him to call for help. Observation on 6/1/24 at 1:40 PM of Resident #1's room revealed the bed remained at a normal height and fall mat remained in the same position against the wall on the other side of the room. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/1/24 at 10:25 AM with Resident #1's FM revealed there is a concern that he will reinjure his head with all these falls he has been experiencing at the facility. The FM stated he had a TBI in 2004 and recently a few months ago was found wandering around after a fall at his apartment and his brain bled again causing the damage to his brain to be worse. They were told that he does not need to be getting any further injuries to his head. The FM stated the facility is frequently calling family saying that he has fallen but they will lower his bed and use a mat beside his bed. It does not seem to have worked. The FM stated I wish they would understand that he is probably trying to take himself to the bathroom when he falls, does anyone ever ask him if he needs to go to the bathroom and offer to help. He frequently is urinating in clothes baskets and trash cans. He has brain damage he cannot remember to call for help, they say they are reminding him but that is not helping either. The FM stated they have not been asked to meet with a team to discuss a plan of care about him they have just been telling ideas to random people that they meet one time then the next time they go it will be somebody new in that position. The FM has tried explaining to staff Resident #1 is left-handed and gets up from the bed easier if he can use that side, but they have the bed positioned so that is not possible . The FM stated it seems as though it is just a matter of time before he has a fall that will hospitalize him again. Interview on 6/1/24 at 1:45 PM with CNA A who had worked the 6am to 2pm shift, revealed that she was unable to speak English. When the surveyor pointed to the mat folded against the wall and asked if it was for Resident #1, MA B came in from the hallway and said CNA A did not understand what the surveyor was asking but it was a mat for Resident #1 and the bed was supposed to be in a low position but Resident #1 must have moved the mat and lowered the bed. MA B was asked to ask CNA A if she was aware the bed was to be low and fall mat was to be beside his bed, and CNA A shook her head No. MA B stated CNA A knows now because she just explained it to her. Interview on 6/1/24 at 1:47 PM with MA B revealed she had been aware of fall precautions were to be in place for Resident #1 but had not noticed today that they were not in place. When asked how she and the CNAs learn who is on fall precautions she stated the nurse for the hall would tell the staff in the morning rounds. Interview on 6/1/24 at 1:58 PM with RN C revealed he is the nurse for Resident #1's hall working the 6 AM to 6 PM shift. RN C stated he was made aware this morning during report, from the previous nurse, that Resident #1 had returned from the hospital yesterday after a fall during which he had hit his head. RN C stated the nurse had written on the 24-hour report that the resident was a high fall risk, but RN C was not aware that included the use of the fall mat and bed in lowest position, therefore he was not checking for those things this shift and had not told CNA A anything other than Resident #1 was a high fall risk. Interview on 6/1/24 at 2:04 PM with the facility DON revealed the mat and bed in low position would normally be in place, but the hospital had returned Resident #1 last night without giving them a heads up that he was returning and therefore the staff had probably not been prepared for him. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/1/24 at 2:23 PM with CNA E revealed she is working the 2-10 shift tonight on Resident #1's hall. CNA E stated she has worked with Resident #1 multiple times during the month he has been here, but he has not fallen while she was working with him. She stated until today when she came into work, she was not aware that they were to be having the bed in the lowest position and a fall mat in place. CNA E stated she has seen Resident #1's bed low and fall mat in place but she did not know they were always supposed to have those precautions in place. CNA E stated there is not a place where the CNAs can look to see interventions/ care plan or what they are to do but the nurses will tell them when they come to work. If they have a question they can ask the nurse if they are available. CNA E stated the area where the CNAs document does say Resident #1 is high fall risk. But does not say anything about the bed position or fall mat. Interview on 6/1/24 at 3:07 PM with NP Q revealed she normally would be the NP for Resident #1. She stated she did not know about any of the falls except the one recently when he hit his head of the floor, so she sent him to the hospital. Her expectation is that if a resident has more than one fall, fall precautions are put in place. Interview on 6/2/24 at 9:56 AM with LVN F revealed that she had just come to work at 6 AM and was told Resident #1 was a 1:1 now because of the number of falls he had since his admission. LVN F stated she knew about his falling before today but felt like the nursing staff was doing all they could to protect him. If he falls, they lower his bed and put the mat down next to the bed. Now they will be adding the soft helmet. When asked how long the bed is to stay on low and fall mats should be in place, she said it probably should stay that way but if not, then they do it each time he falls. Interview on 6/2/24 at 10:04 AM with CNA G revealed today is her first day to work with Resident #1. She stated she is providing the 1:1 and was told to make sure she uses the fall mat and document every 30 minutes what he is doing. She stated he mostly has been sleeping but when she asks him if he wants to go to the dining room or if he needs to go to the bathroom he does so without problems. CNA G stated she is trying to teach him to use the call light, and he seems to understand. Interview on 6/2/24 at 2:20 PM with CNA E revealed she will be providing Resident #1's 1:1 supervision tonight. She knows he needs to have the helmet, the bed in low position and the mat on the floor in front of the bed when he is in bed. When asked how she was aware of all that she said the nurse let her know and there is an in-service she read today. When asked if she is always able to remember each person's needs, she stated usually but if she does not, she can ask the nurse, and she has heard it is being added to the CNA's POC . When asked if she could show the surveyor the plan of care that CNAs use, she agreed. We went to the nurse's station, and she showed the surveyor where they document the amount of meals eaten and if the resident had been checked on every 2 hours. When asked where the mat, bed, 1:1 and helmet info was she initially was not sure and asked another staff to show her. The other staff found where there is a check off for whether the resident is incontinent and the use of the helmet, which was added today. There is no mention of the low bed or the fall mat use. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/2/2024 at 11:49 AM with the MDS Nurse revealed he does at times add needed items to the care plans of residents, but he works as needed and part time. The MDS nurse stated that the DON and SW can also add anything needed. He does not recall developing a care plan for Resident #1, but he may have. He stated when someone was admitted it is usually the nursing staff or DON that will initiate a care plan. The MDS nurse stated when they are answering the section in the MDS assessment about falls they are only looking at the previous 7 days. If Resident #1 had as many falls as you are describing it should have been added to the care plan by the DON since he is usually only at the facility on weekends. The MDS nurse was asked if there is a purpose for the CNAs to see the interventions in the POC and he stated so that they can know those things need to be done for the residents. He stated he went over the Care Plan for Resident #1 yesterday and they added falls and the use of a fall mat and soft helmet. Interview on 6/3/24 at 3:30 PM with the facility DON revealed that when asked if he could provide any documentation regarding interventions and/or precautions put in place to prevent further falls he stated when a fall occurred, they put out a fall mat and have the bed in lowest position, that is the interventions. The nurses do so after every fall. When asked about documentation of these interventions the DON stated the nurse's progress notes will contain that information. When asked if the falls are being tracked for patterns which may provide additional interventions, the DON stated other interventions are listed on internal documents that could not be shared with the surveyor, and the falls are reviewed in the morning meetings. Investigations are performed by the nursing staff and are included in the progress notes. Additionally, the facility's written Incident Reports are internal documents that also could not be provided. He suggested the surveyor look at the progress notes of the nurses to obtain information needed. The DON stated he just became aware yesterday that he can add areas of focus to the care plan, he had not known before, and he agrees it should be added for this resident. Interview on 6/3/24 at 3:35 PM with the Administrator revealed he is aware there is a problem with the care plans. They have hired a new SW and have the MDS nurse so plan to make all corrections soon. The ADM stated they review all investigations that the nurse writes in the progress notes, during the morning meeting and are considering that as an interdisciplinary meeting for everyone who had an incident and/or accident. All department heads, administrators, nursing, wound care nurse, the DON, the activities person, and rehab medical director will sign off if there are any orders as a result of the meeting. The Administrator stated the fall precautions were put in place after each fall by the nursing staff. Each time a fall was documented it automatically populated the fall risk assessment, the bed being lowered to the lowest position and a fall mat being placed at the bedside. The Administrator stated they cannot prevent a person from falling that is an unrealistic expectation. The Administrator confirmed knowing that investigations at times provided other interventions such as the possibility of a toileting program to prevent Resident #1 from attempting to get up without assistance. He was not aware that Resident #1's family felt falls could be related to him trying to get to the toilet. Review of the facility policy titled Care Planning, undated, revealed, the Purpose of the policy is: To ensure that a comprehensive person-centered care plan is developed for each resident based on their individual assessed needs. The policy includes that each resident's plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I. The facility Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MDS Guideline II. The Care Plan serves as a course of action where resident (resident family and/or guardian or other legally authorized representative), resident's attending physician, and IDT work to help the resident move toward resident specific goals that address the resident's medical nursing, mental and psychosocial needs. III. A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/NDS guidelines and updated as indicated for change in condition, onset of new problems resolution of current problems and as deemed appropriate by clinical assessment and judgement on an as needed bases . The ADM was notified on 06/01/2024 at 06:03 PM, that an IJ situation was identified due to the above failures and the IJ template was provided. The Plan of Removal was accepted on 06/04/2024 at 12:35 PM, and included: Plan of Removal Immediate Jeopardy On 06/01/2024 an abbreviated survey was initiated at the facility. On 06/01/2024 the surveyor provided an Immediate Jeopardy Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of immediate Jeopardy states as follows: F656 -The facility failed to develop and implement a comprehensive person-centered care plan for each resident. Resident #1's care plan did not include interventions to possibly prevent falls despite a history of falls with serious injuries. Action: A Fall reassessment for Resident #1 was completed by DON on 6/1/24 and the Care Plan was updated on 6/1/24 for Resident #1 to reflect the appropriate interventions to try to help prevent injury from further falls. Resident #1 and room was reviewed to ensure that documented interventions were in place as documented in the plan of care. Intervention for safety helmet placement and fall monitoring rounds was implemented. An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on the fall management program policy and procedure along with communicating updated interventions during shift change and staff responsibilities, prior to them working the floor. All staff were re-educated on the regulatory guidelines and facility policy and procedures regarding Abuse, Neglect and Exploitation. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Start Date: 06/01/2024 Completion Date: 06/01/2024 Responsible: DON Action: A full house fall risk reassessment was implemented and completed by DON for all residents to ensure no additional residents are at risk, and Care Plans will be updated to reflect appropriate fall interventions. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: DON was reeducated on the facility fall management program policy and procedure along with communicating updated interventions. Start Date: 6/1/24 Completion Date: 6/1/24 Responsible: Clinical Nurse Consultant Action: An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on the fall management program policy and procedure along with communicating updated interventions and staff responsibilities, prior to them working the floor. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON will monitor that clinical staff is compliant with following the Policy and Procedure for the facility's Fall Management Program and their responsibilities which include communication during shift change, review of 24-hour report and implementation of interventions for any resident that is a fall risk. 24-hour report will be reviewed by DON during morning clinical meetings. DON will report progress with monitoring to the QAPI team for review to implement any needed changes or updates to ensure compliance. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: New system implementation of tracking resident falls and interventions in a fall tracking binder for daily review by charge nurses which will help identify residents with multiple falls and appropriate interventions. DON will audit binder for updates and completeness. DON will audit the binders daily for a week, biweekly for a month, monthly for QAPI. Audit results will be reviewed and shared with QAPI team. Start Date: 06/02/2024 Completion Date: 06/03/2024 Responsible: DON Action: An Ad-[NAME] QAPI meeting was held by DON, MD, and Administrator regarding facility fall management program policy and procedure along with communicating updated interventions. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON The Surveyor monitored the POR on 06/04/24 as followed: During an interview on 6/4/24 at 9:35 AM with the Facility DON revealed. In-serviced staff on falls and ANE. Monitoring fall risk residents' daily and documenting to ensure interventions implemented and for any new incidents. No new incidents. Resident #1 family aware Resident #1 would get out of bed independently without asking for assistance and aware of Resident #1's impulsiveness, which was why Resident #1's family placed him in facility because they could not manage how often Resident #1 would fall. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 9:40 AM with the ADM, he said the facility updated Resident #1's care plan, implemented a new binder system on fall risk, put helmet on Resident #1, removed electronic control from bed, and ordered a PVC bed that would go on the floor for Resident #1 when the order arrived. Observation and interview on 6/4/24 at 10:16 AM of Resident #1 revealed he was lying in bed. Resident #1 was clean, dressed, and comfortable. Resident #1 had a fall mat next to his bed. Resident #1's bed was in low position. CNA J was sitting in a chair with 1:1 monitoring sheets across Resident #1. Resident #1 had two postings on the wall behind his bed that stated he was to wear a helmet when he got out of bed at all times and that he must have a fall mat next to his bed at all times. During an interview, Resident #1 stated he was doing fine, staff checked on him often, he had some falls in the past, staff were monitoring him, he wore a helmet whenever he got out of bed, his fall mat was always next to his bed, his bed was always in lowest position, and he had no concerns or issues. On 6/4/23 at 10:23am the facility POR for F656 was approved. During an interview on 6/4/24 at 10:21AM, CNA J revealed she was 1:1 monitoring Resident #1. CNA J stated she filled out a monitoring form that was submitted to the Charge Nurse at the end of her shift reflecting she monitored Resident #1 every 30 minutes. CNA J stated Resident #1 had no falls since her shift. CNA J also stated Resident #1's bed had been in the lowest position, had a fall mat next to his bed, and Resident #1 had been wearing a helmet for a while. CNA J did not know how long Resident #1 had the interventions that were previously mentioned or when the interventions started. She was in-serviced on falls and ANE before she started her shift. She learned how to prevent falls, listening to call lights, ensuring beds were at lowest position, ensuring fall mat on floor, ensuring belongings within reach, ensuring Resident #1 wore safety helmet, who and how to report ANE, and ADM was the abuse and neglect coordinator. During an interview on 6/4/24 at 10:30 AM, RN H revealed she had conducted 1:1 monitoring for Resident #1. RN H stated she documented the 1:1 monitoring every 30 minutes on a log. RN H also stated CNAs are 1:1 monitoring Resident #1 and logging their monitoring during their shift every 30 minutes. RN H stated she was in-serviced on falls and ANE. RN H also stated Resident #1 had a helmet on anytime he was out of bed, had a fall mat next to his bed at all times, and bed was in lowest position. RN H was in-serviced on how to respond to falls, resident rights, who and how to report ANE, and ADM was the abuse and neglect coordinator. Reviewed fall tracking binder daily. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/4/24 at 12:33 PM, ADM stated DON completed Resident #1's fall reassessment on 06/01/24. ADM also stated Resident #1's care plan was updated by the facility MDS Coordinator on 06/01/24. ADM stated DON reviewed Resident #1's room to ensure care plan interventions were implemented on 06/01/24. ADM also stated Resident #1's fall monitoring rounds conducted by clinical staff (nurses and CNAs) started every 30 minutes on 06/02/24 and ongoing. Resident #1's safety helmet placement was implemented. DON in-serviced clinical staff on fall management and ANE started on 06/01/24 and ongoing before staff started shifts. ADM stated he did not know CNA M was not in-serviced prior to starting his work shift on ANE and falls. DON conducted fall risk reassessment on all residents started on 06/01/24 and completed 06/02/24. He was not sure if there were any other residents identified as at risk and if there were any other residents who required updated care plans to reflect appropriate fall interventions. Clinical Nurse Consultant reeducated DON on fall management policy and procedure on 06/01/24. DON started daily monitoring clinical staff to ensure compliant with fall management by auditing the new system implementation of tracking resident falls and interventions in a fall tracking binder that was daily reviewed by charge nurses on 06/02/24. DON started reviewing all residents' 24-hour reports during morning clinical meetings started on 06/01/24 and completed 06/02/24. On 06/02/24, him, DON, and MD had QAPI meeting. DON reported progress with monitoring during the meeting. No changes or updates to ensure compliance needed to be done following QAPI meeting to discuss 24-hour reports. Charge nurses daily reviewed new system implementation of tracking falls and interventions from fall tracking binder started on 06/02/24 and ongoing. Observation on 6/4/24 at 1:17 PM of Resident #1 revealed he was sitting in his wheelchair and wore a safety helmet while watching tv in his room. During an interview on 6/4/2024 at 1:48 PM with the MDS Coordinator revealed he updated Resident #1's care plan on 06/02/24. He and the DON updated residents' care plans to reflect fall interventions on 06/01/24 and was ongoing. During an interview on 6/4/24 at 2:08 PM with the Clinical Nurse Consultant revealed she reeducated DON on 06/01/24 on fall management policy and procedure. During an interview on 6/4/24 at 2:11 PM, the ADM revealed Resident #1's safety helmet was implemented on 06/02/24. Review of the facility's in-services revealed clinical staff were trained on fall prevention protocol and interventions on 06/01/24-06/03/24. Review of Resident #1's care plan revealed his care plan was reviewed and revised on 06/01/24 to reflect new interventions. Review of Resident #1's progress notes revealed the following: On 6/1/24 at 7:57 PM RN H documentation included that Resident #1 was a high fall risk having had more than four falls the previous month. Resident #1's Care Plan was updated with fall risk prevention and management in-service was conducted regarding fall risk management and prevention. 1:1 sitter was implemented for his safety, other fall safety prevention was carried out including the bed in the lowest position, call light within reach and a fall mat next to his bed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Austin Wellness & Rehabilitation	11406 Rustic Rock Drive Austin, TX 78750

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/2/24 at 10:53 AM LVN F documented Resident #1 remained with a 1:1 sitter, call light was within reach and resident was educated several times to use call light for help. During an interview on 6/4/24 at 2:18 PM, DON revealed he completed fall reassessment on Resident #1 on 06/01/24. MDS Coordinator and him sat and revised Resident #1's care plan on 06/01/24. He conducted fall risk assessment again on all residents on 06/02/24. There were some residents who were flagged as fall risks and nurses flagged some residents because nurses believed they were fall risks. He and the MDS Coordinator updated PCC profile to reflect residents were fall risks and the nurses and MDS coordinator updated care plans to reflect fall interventions started on 06/01/24 and ongoing. Clinical Nurse Consultant reeducated him over the phone on fall program policy and procedure on 06/01/24. She taught him on pulling fall reports, fall risk assessments, bed positioning, fall mat implementation, safety helmets, binder to track falls, ANE, and wander guards. He reviewed 24-hour reports during morning clinical meetings since his employment. He did not have anything to report to QAPI during meeting that needed changes or updates to ensure compliance. He started auditing the fall tracking binder daily since 06/02/24. 1:1 monitoring on the night of 06/01/24. He, ADM, and MD attended QAPI meeting on 06/02/24. Review of residents who were high risk for falls in PCC revealed care plans revised for fall risk, interventions, and PCC profile noted they were fall risks. Review of the facility's QAPI meeting, dated 06/02/24, revealed ADM, DON, and MD attended. The ADM was notified on 06/04/2024 at 03:50 PM that the Immediate Jeopardy was lowered. While the IJ was removed on 06/04/2024, the facility remained out of compliance at a scope of isolated and a severity of no actual harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of the corrective systems.

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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** 17141 Based on record reviews, observations and interviews, the facility failed to ensure a resident's environment remained free of accident hazards and residents received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards. The facility failed to ensure Resident #1 did not have repeated falls without attempts to decrease the severity and frequency of falls that continued to occur despite the same two interventions used each time a fall occurred. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 06/01/24 at 6:03PM and the facility was notified and given an IJ template. While the IJ was removed on 06/04/24 at 4:00 PM, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice placed residents at risk for falls possibly resulting in injuries including traumatic brain injury, hospitalization and/or death. Findings included: Review of Resident #1's Face sheet, undated, revealed he was admitted to the facility on [DATE] from a local hospital. Resident #1's admitting diagnoses included traumatic subdural hemorrhage (brain injury resulting in a bleed from a vessel causing blood to collect between the brain and skull), epileptic seizures, fracture of skull and facial bones, unspecified fall. Review of Resident #1's Local Hospital Discharge Summary dated 4/29/24 revealed Resident #1 had been admitted on [DATE] with a problem list of 1.Fall with Injury (Acute, Onset:3/13/24) 2. Intercranial subdural hemorrhage (Acute, Onset:03/13/24) discharge date [DATE] Discharge diagnosis: Found down with TBI Pt condition on discharge: stable Review of Resident #1's 5-day MDS, dated [DATE] revealed a BIMs score of 10 indicating moderate cognitive impairment. In section J for the question asking has the resident had a fall in the last month prior to admission/entry or reentry the answer is yes. For any falls since Admission/entry or reentry or prior assessment the answer is no. (Resident #1 had falls on 5/1 and 5/2.). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Admission MDS, dated [DATE] revealed a BIMs score of 10 indicating moderate cognitive impairment. Section GG notes Resident #1 is dependent on staff helper does all the effort to walk ten feet. In section J for the question asking has the resident had a fall in the last month prior to admission/entry or reentry the answer is No. For any falls since Admission/entry or reentry or prior assessment the answer is no. (Resident #1 had falls on 5/1 and 5/2.) Review of Resident #1's Care Plan revealed falls are not included in the areas addressed. The only area addressed with a goal and interventions is elopement initiated on 4/29/24. Another focus listed was the resident requires antidepressant medication there are instructions to include the medication and the diagnosis, however, neither are included. There are no goals and no interventions. The focus area was initiated 5/1/24. The third and final focus states the resident has impaired cognitive function/dementia or impaired thought processes. The goal is the resident will maintain his current level of cognitive functioning. No interventions are listed. Review of Resident #1's Nursing Progress Notes reveals falls on 5/1/24, 5/2/24, 5/4/24, 5/5/24, 5/10/24, 5/15/24, and 5/30/24, which detail the following: 5/1/24 at 2:14 PM [Physician name] told this nurse resident fell on the floor. This nurse went in his room. Resident lying down on the right side of the bed. Resident complained of pain on both knees, has old scabs, said hit his head. [Physician Name] also assessed resident and got order to send resident out for CT scan. Took a set of vital signs and called non-emergent transportation. DON aware of it. 11pm resident returned from hospital scan was clear, denied pain no signs or symptoms of distress. 5/2/24 at 1:16 PM Resident was found on floor of his room, no visible injuries were noted he denies pain, and said he fell on the left knee. The administrator was notified, voice message left on MD on call number and the [family member] was notified. 5/5/24 at 2:44 PM Staff reports to the nurse that the resident is lying on the floor, Nurse walks into the resident room and see the resident lying between both beds, head on floor, resident reports I fell out of my chair, Intervention: Head to toe assessment, pain medication, on call NP notified, family aware. Plan to initiate neuros , Nursing will notify NP of any change of condition. 5/6/24 at 9:40 PM Resident noted on the floor by the bathroom door in his room, wheelchair beside him assessed for injuries none noted assisted to the bed, resident able to move extremities. 5/13/24 at 3:53 AM Resident noted on the floor in his room on his stomach by the window, bed on the lowest position. Resident stated he rolled off the bed. Assessed for injuries assisted to bed, NP/DON notified. Resident continues neuros as per facility protocol denied pain. 5/16/24 at 7:02 PM Resident was found lying on floor beside his wheelchair, no injuries noted at time of assessment. Resident was safely assisted back in wheelchair. Vitals and neuro checks conducted on him. NP notified of his condition, [family member] notified, all fall safety protocol carried out on him, fall mat next to his bed, bed in lowest position and call light within reach. Encouraged him to use call light if needs assistance, he verbalized understanding. DON notified of the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/30/24 at 4:35 PM Resident was found on the floor in his room close to the bathroom door he had a bump at the back of his head, he denies pain. Resident was transferred to hospital for further assessment. The [family member] was notified, and the NP was also notified. 5/31/24 at 7:36 PM Resident returned from hospital. Hospital admission for unwitnessed fall with impact to back of head. No new findings at the hospital. Review of an Incident Report summary for the month of May 2024 revealed Resident #1 listed as having falls on 5/1, 5/2, 5/5, 5/6 and 5/13. The summary consist of the resident's name, date, time, and the words fall, no injury. A review of the actual detailed Incident Reports was attempted but the documents were not provided, due to being considered internal documents. Review of Resident #1's Fall Risk Evaluations revealed an initial admission evaluation dated 4/29/24 with a score of 20 indicating high fall risk. Resident #1 was noted to be chair bound and requires assistance with toileting, having balance problems while standing, walking, or sitting, unable to stand independently. On 5/2/24 a post fall assessment shows Resident #1's fall risk score is noted to be twelve indicating high risk. On 5/5/24 a post fall assessment shows a score of 11 indicating high risk. On 5/6/24 a post fall assessment shows a score of 9 which does not indicate a high risk. On 5/16/24 a post fall risk assessment shows a score of 20 indicating high risk. Observations on 6/1/24 at 9:40 AM of Resident #1's room revealed he was sitting in the room attempting to put on his shoes. Resident #1's bed was noted to be neatly made with the call light attached to the top cover and the bed was a normal bed height. A fall mat was noted to be folded against the wall on the opposite side of the room near an empty bed. When asked what the call light was for Resident #1 was unsure . When asked if he could use it to call for help such as when going to the bathroom, Resident #1 denied that he needed help and began to stand from his wheelchair. Resident #1 was able to read a sign on his wall that said his family did his laundry but there were no other signs including any to prompt him to call for help. Observation on 6/1/24 at 1:40 PM of Resident #1's room revealed the bed remained at a normal height and fall mat remained in the same position against the wall on the other side of the room. Observation on 6/2/24 at 9:53 AM revealed Resident #1 was in his room in bed and appeared to be asleep. Resident #1's bed was in the lowest position; a fall mat was next to his bed and there was a 1:1 staff sitting in his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/1/24 at 1:45 PM with CNA A who had worked the 6am to 2pm shift, revealed that she was unable to speak English. When the surveyor pointed to the mat folded against the wall and asked if it was for Resident #1. MA B came in from the hallway and said CNA A did not understand what the surveyor was asking but it was a mat for Resident #1 and the bed was supposed to be in a low position but Resident #1 must have moved the mat and lowered the bed. MA B was asked to ask CNA A if she was aware the bed was to be low and fall mat was to be beside his bed, and CNA A shook her head No. MA B stated CNA A knows now because she just explained it to her. Interview on 6/1/24 at 1:47 PM with MA B revealed she had been aware of fall precautions were to be in place for Resident #1 but had not noticed today that they were not in place. When asked how she and the CNAs learn who is on fall precautions she stated the nurse for the hall would tell the staff in the morning rounds. Interview on 6/1/24 at 1:58 PM with RN C revealed he is the nurse for Resident #1's hall working the 6 AM to 6 PM shift. RN C stated he was made aware this morning during report, from the previous nurse, that Resident #1 had returned from the hospital yesterday after a fall during which he had hit his head. RN C stated the nurse had written on the 24-hour report that the resident was a high fall risk, but RN C was not aware that included the use of the fall mat and bed in lowest position, therefore he was not checking for those things this shift and had not told CNA A anything other than Resident #1 was a high fall risk. Interview on 9/1/24 at 2:04 PM with the facility DON revealed that the mat and bed in low position would normally be in place but the hospital had returned Resident #1 last night without giving them a heads up that he was returning and therefore the staff had probably not been prepared for him. Interview on 6/1/24 at 2:23 PM with CNA E revealed she is working the 2-10 shift tonight on Resident #1's hall. CNA E stated she has worked with Resident #1 multiple times during the month he has been here, but he has not fallen while she was working with him. She stated until today when she came into work, she was not aware that they were to be having the bed in the lowest position and a fall mat in place. CNA E stated she has seen Resident #1's bed low and fall mat in place but she did not know they were always supposed to have those precautions in place. CNA E stated there is not a place where the CNAs can look to see interventions/ care plan or what they are to do but the nurses will tell them when they come to work. If they have a question they can ask the nurse if they are available. CNA E stated the area where the CNA's document does say high fall risk. But does not say anything about the bed position or fall mat. Interview on 6/1/24 at 3:07 PM with NP Q revealed she normally would be the NP for Resident #1. She stated she did not know about any of the falls except the one recently when he hit his head of the floor, so she sent him to the hospital. Her expectation is that if a resident has more than one fall, fall precautions are put in place. Interview on 6/2/24 at 9:56 AM with LVN F revealed that she had just come to work at 6 AM and was told Resident #1 was a 1:1 now because of the number of falls he had since his admission. LVN F stated she knew about his falling before today but felt like the nursing staff was doing all they could to protect him. If he falls, they lower his bed and put the mat down next to the bed. Now they will be adding the soft helmet. When asked how long the bed is to stay on low and fall mats should be in place, she said it probably should stay that way but if not, then they do it each time he falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/2/24 at 10:04 AM with CNA G revealed today is her first day to work with Resident #1. She stated she is providing the 1:1 and was told to make sure she uses the fall mat and document every 30 minutes what he is doing. She stated he mostly has been sleeping but when she asks him if he wants to go to the dining room or if he needs to go to the bathroom he does so without problems. CNA G stated she is trying to teach him to use the call light, and he seems to understand. Interview on 6/2/24 at 2:20 PM with CNA E revealed she will be providing Resident #1's 1:1 supervision tonight. She knows he needs to have the helmet, the bed in low position and the mat on the floor in front of the bed when he is in bed. When asked how she was aware of all that she said the nurse let her know and there is an in-service she read. When asked if she is always able to remember each person's needs, she stated usually but if she does not, she can ask the nurse, and she has heard it is being added to the CNAs POC . When asked if she could show the surveyor the plan of care that CNA's use, she agreed. We went to the nurse's station, and she showed the surveyor where they document the amount of meals eaten and if the resident had been checked on every 2 hours. When asked where the mat, bed, 1:1 and helmet info was she initially was not sure and asked another staff to show her. The other staff found where there is a check off for whether the resident is incontinent and the use of the helmet, which was added today. There is no mention of the low bed or the fall mat use. Interview on 6/2/2024 at 11:49 AM with the MDS Nurse revealed he does at times add needed items to the care plans of residents, but he works as needed and part time. The MDS nurse stated that the DON and SW can also add anything needed. He does not recall developing a care plan for Resident #1, but he may have. He stated when someone was admitted it is usually the nursing staff or DON that will initiate a care plan. The MDS nurse stated when they are answering the section in the MDS assessments about falls they are only looking at the previous 7 days. If Resident #1 had as many falls as you are describing it should have been added to the care plan by the DON since he is usually only at the facility on weekends. The MDS nurse was asked if there is a purpose for the CNAs to see the interventions in the POC and he stated so that they can know those things need to be done for the residents. He stated he went over the Care Plan for Resident #1 yesterday and they added falls and the use of a fall mat and soft helmet. Interview on 6/1/24 at 10:25 AM with Resident #1's FM revealed there is a concern that he will reinjure his head with all these falls he has been experiencing at the facility. The FM stated he had a TBI in 2004 and recently a few months ago was found wandering around after a fall at his apartment and his brain bled again causing the damage to his brain to be worse. They were told that he does not need to be getting any further injuries to his head. The FM stated the facility is frequently calling family saying that he has fallen but they will lower his bed and use a mat beside his bed. It does not seem to have worked. The FM stated I wish they would understand that he is probably trying to take himself to the bathroom when he falls, does anyone ever ask him if he needs to go to the bathroom and offer to help. He frequently is urinating in clothes baskets and trash cans. He has brain damage he cannot remember to call for help, they say they are reminding him but that is not helping either. The FM stated they have not been invited to meet with a team to discuss a plan of care about him they have just been telling ideas to random people that they meet one time then the next it will be somebody new in that position. The FM has tried explaining to staff Resident #1 is left-handed and gets up from the bed easier if he can use that side, but they have the bed positioned so that is not possible . The FM stated it seems as though it is just a matter of time before he has a fall that will hospitalize him again. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/3/24 at 3:30 PM with the facility DON revealed that when asked if he could provide any documentation regarding interventions and/or precautions put in place to prevent further falls he stated when a fall occurred, they put out a fall mat and have the bed in lowest position, that is the interventions. The nurses do so after every fall. When asked about documentation of these interventions the DON stated the nurse's progress notes will contain that information. When asked if the falls are being tracked for patterns which may provide additional interventions, the DON stated other interventions are listed on internal documents that could not be shared with the surveyor, and the falls are reviewed in the morning meetings. Investigations are performed by the nursing staff and are included in the progress notes. Additionally, the facility's written Incident Reports are internal documents that also could not be provided he suggested the surveyor look at the progress notes of the nurses to obtain information needed. Interview on 6/3/24 at 3:35 PM with the Administrator revealed he stated they review all investigations that the nurse writes in the progress notes, during the morning meeting and are considering that as an interdisciplinary meeting for everyone who had an incident and/or accident. All department heads, administrators, nursing, wound care nurse, the DON, the activities person, and rehab medical director will sign off if there are any orders as a result of the meeting. The Administrator stated the fall precautions were put in place after each fall by the nursing staff. Each time a fall was documented it automatically populated the fall risk assessment, the bed being lowered to the lowest position and a fall mat being placed at the bedside. The Administrator stated they cannot prevent a person from falling that is an unrealistic expectation. The Administrator confirmed knowing that investigations at times provided other interventions such as the possibility of a toileting program to prevent Resident #1 from attempting to get up without assistance. He was not aware that Resident #1's family felt falls could be related to him trying to get to the toilet. Review of the facility policy titled Response to Falls, undated, revealed the purpose of the policy is To ensure the Facility responds quickly and appropriately to resident falls in a manner that addresses both the resident's immediate needs and longer-term fall prevention. The policy includes that after each fall the nurse will complete a post fall assessment and investigation. The investigation will help identify circumstances or factors contributing to the resident's fall. Any identified findings and the Facility's response will be documented in the resident's medical record as appropriate. The IDT will review the investigative reports on a regular basis, as they occur and make systemic changes to reasonably limit future occurrences, consider change in POC interventions, system changes, etc. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Facility Nursing Manual/Policy titled Fall Evaluation and Prevention, undated, revealed the purpose of the document is To ensure the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. Policy is listed as The facility will evaluate residents for their fall risk and develop interventions for prevention. Upon Admission, the nursing staff/ interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so that the staff can determine what intervention is not successful and needs to be changed. And in a section under procedure, titled Risk Factors Associated With A Fall, Intrinsic risk factors for falls include changes that are part of normal aging as well as certain acute or chronic conditions and medications. The following are examples of intrinsic risk factors including incontinence and previous falls. Interventions include evaluate and implement toileting program if indicated, provide adequate lightening , and remove obstacles in path. Evaluate medications to determine if any can be discontinued or administration times can be changed. The ADM was notified on 06/01/2024 at 06:03 PM, that an IJ situation was identified due to the above failures and the IJ template was provided. The Plan of Removal was accepted on 06/04/2024 at 12:35 PM, and included: Plan of Removal Immediate Jeopardy On 06/01/2024 an abbreviated survey was initiated at [the facility]. On 06/01/2024 the surveyor provided an Immediate Jeopardy Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of immediate Jeopardy states as follows: F689 the facility failed to ensure adequate supervision and assistive devices to prevent Resident #1 from repeated falls. Action: A Fall reassessment for Resident #1 was completed by DON on 6/1/24 and the Care Plan was updated on 6/1/24 for Resident #1 to reflect the appropriate interventions to try to help prevent injury from further falls. Resident #1 and room was reviewed to ensure that documented interventions were in place as documented in the plan of care. Intervention for safety helmet placement and fall monitoring rounds was implemented. An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on the fall management program policy and procedure along with communicating updated interventions during shift change and staff responsibilities, prior to them working the floor. (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	All staff were re-educated on the regulatory guidelines and facility policy and procedures regarding Abuse, Neglect and Exploitation. Start Date: 06/01/2024 Completion Date: 06/01/2024 Responsible: DON Action: A full house fall risk reassessment was implemented and completed by DON for all residents to ensure no additional residents are at risk, and Care Plans will be updated to reflect appropriate fall interventions. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: DON was reeducated on the facility fall management program policy and procedure along with communicating updated interventions. Start Date: 6/1/24 Completion Date: 6/1/24 Responsible: Clinical Nurse Consultant Action: An All-Clinical Staff in-service by DON to include FT/PT/PRN/New Hires (No Agency in Use) on the fall management program policy and procedure along with communicating updated interventions and staff responsibilities, prior to them working the floor. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455799	A. Building B. Wing	06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DON will monitor that clinical staff is compliant with following the Policy and Procedure for the facility's Fall Management Program and their responsibilities which include communication during shift change, review of 24-hour report and implementation of interventions for any resident that is a fall risk. 24-hour report will be reviewed by DON during morning clinical meetings. DON will report progress with monitoring to the QAPI team for review to implement any needed changes or updates to ensure compliance. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON Action: New system implementation of tracking resident falls and interventions in a fall tracking binder for daily review by charge nurses which will help identify residents with multiple falls and appropriate interventions. DON will audit binder for updates and completeness. DON will audit the binders daily for a week, biweekly for a month, monthly for QAPI. Audit results will be reviewed and shared with QAPI team. Start Date: 06/02/2024 Completion Date: 06/03/2024 Responsible: DON Action: An Ad-[NAME] QAPI meeting was held by DON, MD, and Administrator regarding facility fall management program policy and procedure along with communicating updated interventions. Start Date: 06/01/2024 Completion Date: 06/02/2024 Responsible: DON The Surveyor monitored the POR on 06/04/24 as followed: During an interview on 6/4/24 at 9:35 AM with the Facility DON revealed In-serviced staff on falls and ANE. Monitoring fall risk residents' daily and documenting to ensure interventions implemented and for any new incidents. No new incidents. Resident #1 family aware Resident #1 would get out of bed independently without asking for assistance and aware of Resident #1's impulsiveness, which was why Resident #1's family placed him in facility because they could not manage how often Resident #1 would fall. (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 6/4/24 at 9:40 AM with the ADM, he said the facility updated Resident #1's care plan, implemented a new binder system on fall risk, put helmet on Resident #1, removed electronic control from bed, and ordered a PVC bed that would go on the floor for Resident #1 when the order arrived. Observation and interview on 6/4/24 at 10:16 AM of Resident #1 revealed he was lying in bed. Resident #1 was clean, dressed, and comfortable. Resident #1 had a fall mat next to his bed. Resident #1's bed was in low position. CNA J was sitting in a chair with 1:1 monitoring sheets across Resident #1. Resident #1 had two postings on the wall behind his bed that stated he was to wear a helmet when he got out of bed at all times and that he must have a fall mat next to his bed at all times. During an interview, Resident #1 stated he was doing fine, staff checked on him often, he had some falls in the past, staff were monitoring him, he wore a helmet whenever he got out of bed, his fall mat was always next to his bed, his bed was always in lowest position, and he had no concerns or issues. On 6/4/23 at 10:23am the facility POR for F689 was approved. During an interview on 6/4/24 at 10:21AM, CNA J revealed she was 1:1 monitoring Resident #1. CNA J stated she filled out a monitoring form that was submitted to the Charge Nurse at the end of her shift reflecting she monitored Resident #1 every 30 minutes. CNA J stated Resident #1 had no falls since her shift. CNA J also stated Resident #1's bed had been in the lowest position, had a fall mat next to his bed, and Resident #1 had been wearing a helmet for a while. CNA J did not know how long Resident #1 had the interventions that were previously mentioned or when the interventions started. She was in-serviced on falls and ANE before she started her shift. She learned how to prevent falls, listening to call lights, ensuring beds were at lowest position, ensuring fall mat on floor, ensuring belongings within reach, ensuring Resident #1 wore safety helmet, who and how to report ANE, and ADM was the abuse and neglect coordinator. During an interview on 6/4/24 at 10:28 AM, CNA K revealed he had not conducted 1:1 monitoring for Resident #1 yet. CNA K stated Resident #1 was impulsive and often tried to get out of bed independently without asking for help and would end up on his fall mat. CNA K also stated Resident #1 was reeducated by staff to use his call light for assistance, but Resident #1 still would not use it and often tried to get out of bed independently. He was in-serviced on falls and ANE before he started his shift. Learned how and who to report ANE to, ADM was the abuse and neglect coordinator, and how to respond to falls. During an interview on 6/4/24 at 10:30 AM, RN H revealed she had conducted 1:1 monitoring for Resident #1. RN H stated she documented the 1:1 monitoring every 30 minutes on a log. RN H also stated CNAs are 1:1 monitoring Resident #1 and logging their monitoring during their shift every 30 minutes. RN H stated she was in-serviced on falls and ANE. RN H also stated Resident #1 had a helmet on anytime he was out of bed, had a fall mat next to his bed at all times, and bed was in lowest position. RN H was in-serviced on how to respond to falls, resident rights, who and how to report ANE, and ADM was the abuse and neglect coordinator. Reviewed fall tracking binder daily. During an interview on 6/4/24 at 10:35 AM, CNA M stated he was not in-serviced on falls and ANE. (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 6/4/24 at 10:40 AM, Nurse L revealed she was in-serviced on falls and ANE. She learned about fall preventative devices, monitoring, safety protocols, ADM was the abuse and neglect coordinator, and how and who to report. Nurse L stated Resident #1 was impulsive and often tried to get out of bed without asking staff for assistance by call light. Nurse L also stated staff had reeducated Resident #1 on multiple occasions and Resident #1 still would try to get out of bed independently. Nurse L stated Resident #1's family was aware of Resident #1 trying to independently get out of bed. She reviewed the resident fall tracking documentation daily and have reported to CNAs any updates on fall risk. Observation on 6/4/24 at 11:07 AM of 2400 hall revealed residents who were fall risks had fall preventative devices in their rooms, such as fall mats and lowered beds. During an interview on 6/4/24 at 12:33 PM, ADM stated DON completed Resident #1's fall reassessment on 06/01/24. ADM also stated Resident #1's care plan was updated by the facility MDS Coordinator on 06/01/24. ADM stated DON reviewed Resident #1's room to ensure care plan interventions were implemented on 06/01/24. ADM also stated Resident #1's fall monitoring rounds conducted by clinical staff (nurses and CNAs) started every 30 minutes on 06/02/24 and ongoing. Resident #1's safety helmet placement was implemented. DON in-serviced clinical staff on fall management and ANE started on 06/01/24 and ongoing before staff started shifts. ADM stated he did not know CNA M was not in-serviced prior to starting his work shift on ANE and falls. DON conducted fall risk reassessment on all residents started on 06/01/24 and completed 06/02/24. He was not sure if there were any other residents identified as at risk and if there were any other residents who required updated care plans to reflect appropriate fall interventions. Clinical Nurse Consultant reeducated DON on fall management policy and procedure on 06/01/24. DON started daily monitoring of clinical staff to ensure compliance with fall management by auditing the new system implementation of tracking resident falls and interventions in a fall tracking binder that was daily reviewed by charge nurses on 06/02/24. DON started reviewing all residents' 24-hour reports during morning clinical meetings on 06/01/24 and completed 06/02/24. On 06/02/24, him, DON, and MD had QAPI meeting. DON reported progress with monitoring during the meeting. No changes or updates to ensure compliance needed to be done following QAPI meeting to discuss 24-hour reports. Charge nurses daily reviewed new system implementation of tracking falls and interventions from fall tracking binder started on 06/02/24 and ongoing. Review of the facility's Behavior Rounds 06/01/24-06/04/24 revealed staff monitored Resident #1 every 30 minutes and there were no behaviors observed. Observation on 6/4/24 at 1:17 PM of Resident #1 revealed he was sitting in his wheelchair and wore a safety helmet while watching tv in his room. During an interview on 6/4/24 at 1:18 PM MA N revealed he was in-serviced on ANE and falls. He learned any ANE to report to the ADM because he was the abuse and neglect coordinator and he learned to notify a charge nurse if he observed a resident on the ground and ensure resident safety. During an interview on 6/4/24 at 1:21 PM with Translator #9603, CNA O revealed she was not in-serviced on ANE and falls before her shift. She learned to report to her nurses and DON when she observed a resident on the ground and to report ANE. [TRUNCATED]