STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455917	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Creek of Wimberley	555 Ranch Rd 3237 Wimberley, TX 78676

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, or injuries of an unknown source were reported immediately but not later than 24 hours after the allegation was made for one (Resident #1) of four residents reviewed for abuse and neglect. The facility failed to report to the State Survey agency of an injury of unknow origin as Resident #1 was found with a deep purple hematoma to her vaginal area. This deficient practice could place residents at risk of abuse and neglect. Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including encounter for orthopedic aftercare for right hip replacement, age-related osteoporosis (a disease that weakens your bones), muscle weakness, and unsteadiness on feet. Review of Resident #1's admission MDS assessment, dated 05/28/24, reflected a BIMS of 11, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she had a fall in the last month prior to admission but had not had any falls since admission. Section N (Medications) reflected she was on an anticoagulant (blood thinner). Review of Resident #1's admission care plan, dated 05/29/24, reflected she had potential for abnormal bleeding related to anticoagulant use with an intervention of stressing the importance of reporting signs and symptoms of tenderness, swelling, or pain. It further reflected she was at risk for falls with an intervention of needing a safe environment (even floors free from spills and/or clutter, a working and reachable call light, and the bed in low position at night). Review of Resident #1's progress notes, dated 06/20/24 at 5:55 AM and documented by LVN C, reflected the following: This writer heard a thud from the Nurse's station and went to [Resident #1]'s room. [Resident #1] was laying on her right side . Head to toe assessment completed. A small skin tear to her right forearm was cleansed . measurement 1 cm by 1 cm . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes, date 06/20/24 at 10:33 PM and documented by LVN A, reflected the following: Was called to [Resident #1] room by [CNA B] and informed there was abnormalities in the peri-area of the [Resident #1]. When assessed the peri area this nurse noted a hematoma, dark bruising to the vaginal area and right rear buttock, noted swelling to the area . Review of Resident #1's ER records, dated 06/23/24, reflected pictures of bruising to her body. The pictures revealed a dark purple bruise to her left medial thigh, dark bruising to her groin and pelvis area with swelling of her left labia, and dark bruising to her buttocks/perineum. During an interview on 06/25/24 at 11:03 AM, LVN A stated he was notified of Resident #1's hematoma to her vaginal area in the evening of 06/20/24 by CNA B. He stated he assessed her and noted there to be bruising to the pubis and vaginal area running towards the left buttock. He stated when his shift started earlier in the afternoon, he was informed by LVN D that she had a fall earlier that morning. He stated he attributed the bruising to the fall, thinking she may have hit or landed on something. He stated that was the only assumption he had. He stated he did notify the NP and DON. During an interview on 06/25/24 at 11:25 AM, LVN D stated she worked from 6:00 AM - 2:00 PM on 06/20/24. She stated she was told by LVN C at shift change that Resident #1 had a fall earlier that morning but did not mention any injuries. She stated during her shift that day no one brought anything about a hematoma to her vaginal area to her attention. She stated she did complain of generalized pain that day but it was nothing acute. During an interview on 06/25/24 at 12:02 PM, the NP stated she was notified of the hematoma to Resident #1's vaginal area. She stated she assessed her the following day on 06/21/24. She stated she had recently had multiple falls and was on a blood thinner and was informed that RN C believed she fell on a trash can on 06/20/24. She stated Resident #1 did not complain of pain to the area but did complain of burning. She stated she ordered a UA and hip/pelvis x-rays which both came back negative. She stated Resident #1 was sent out to the hospital on 06/23/24 for altered mental status. This Surveyor showed her the pictures from the hospital and she stated when she did her assessment there was no bruising to her buttocks. She stated the increased bruising to her buttocks and lady parts did not surprise her due to her recent falls and being on a blood thinner. During an interview on 06/25/24 at 1:02 PM, Resident #1's RP stated he was notified of the hematoma to her vaginal area. He stated it did concern him and that was why he asked for x-rays to be taken. He stated he was informed it probably happened during a fall and he believed it could have happened during a fall. During a telephone interview on 06/25/24 at 1:34 PM, RN C stated she assessed Resident #1 after the fall on 06/20/24 and did not notice any red areas to her vaginal area. She stated there was a trash can near her when she found her and attributed that to the hematoma that was later noticed by the CNA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/25/24 at 1:55 PM, the DON stated she was notified of the hematoma to Resident #1's vaginal area on 06/21/24. She stated the NP assessed her that day and ordered x-rays. She stated she did not assess Resident #1 herself. She stated Resident #1 is dependent on care, was on a blood thinner, and had recent falls. She stated the resident is dying and her body is failing her. She stated it was reported to her by the NP and RN C that she had fallen on top of a trash can. She stated if she had not had recent falls there would have been a more thorough investigation and would have been reported to HHSC. During an interview on 06/24/24 at 3:22 PM, the AADM stated Resident #1's hematoma was not reported to HHSC because the NP had associated it with the fall she had on 06/20/24. She stated any allegations of abuse or neglect were reported to HHSC. Review of the facility's Abuse and Neglect Policy, revised March of 2018, did not address what/when something should be reported to HHSC.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of four residents reviewed for quality of care. The facility failed to conduct all necessary neurological checks after Resident #1 had unwitnessed falls on 06/17/24 and 06/20/24 and failed to complete a skin assessment after she was found with a hematoma to her vaginal area on 06/20/24. These failures could place residents at risk of uncontrolled pain, injury, and hospitalization . Findings included: Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including encounter for orthopedic aftercare for right hip replacement, age-related osteoporosis (a disease that weakens your bones), muscle weakness, and unsteadiness on feet. Review of Resident #1's admission MDS assessment, dated 05/28/24, reflected a BIMS of 11, indicating a moderate cognitive impairment. Section J (Health Conditions) reflected she had a fall in the last month prior to admission but had not had any falls since admission. Section N (Medications) reflected she was on an anticoagulant (blood thinner). Review of Resident #1's admission care plan, dated 05/29/24, reflected she had potential for abnormal bleeding related to anticoagulant use with an intervention of stressing the importance of reporting signs and symptoms of tenderness, swelling, or pain. It further reflected she was at risk for falls with an intervention of needing a safe environment (even floors free from spills and/or clutter, a working and reachable call light, and the bed in low position at night). Review of Resident #1's progress notes, dated 06/17/24 at 11:13 AM and documented by LVN D, reflected the following: Nurse was in hallway and heard a bang noise, then someone yelling for help. Upon entering room, [Resident #1] was noted on floor, supine. Head against tall clothes cabinet . Abrasion to back of head cleaned and band aid applied . Review of Resident #1's neurological evaluations, from 06/17/24 - 06/20/24, reflected the following: 06/17/24 10:45 AM - evaluation completed 11:00 AM - evaluation completed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:15 AM - evaluation completed 11:30 AM - evaluation not completed 12:00 PM - evaluation not completed 12:30 PM - evaluation not completed 1:00 PM - evaluation not completed 1:30 PM - evaluation not completed 2:30 PM - evaluation not completed 3:30 PM - evaluation not completed 11:30 PM - evaluation completed 6/18/2024 7:30 AM - evaluation not completed 3:30 PM - evaluation not completed 11:30 PM - evaluation completed 6/19/2024 7:30 AM - evaluation completed 3:30 PM - evaluation not completed 11:30 PM - evaluation completed 6/20/2024 7:30 AM - evaluation not completed 3:30 PM - evaluation not completed Review of Resident #1's progress notes, dated 06/20/24 at 5:55 AM and documented by LVN C, reflected the following: This writer heard a thud from the Nurse's station and went to [Resident #1]'s room. [Resident #1] was laying on her right side . Head to toe assessment completed. A small skin tear to her right forearm was cleansed . measurement 1 cm by 1 cm . (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's neurological evaluations, from 06/20/24 - 06/22/24, reflected the following: 06/20/2024 6:15 AM - evaluation completed 6:30 AM - evaluation not completed 6:45 AM - evaluation not completed 7:00 AM - evaluation not completed 7:30 AM - evaluation not completed 8:00 AM - evaluation not completed 9:00 AM - evaluation not completed 10:00 AM - evaluation not completed 6:00 PM - evaluation not completed 06/22/2024 11:00 AM - evaluation completed Review of Resident #1's Head to Toe Skin Check, dated 06/24/24 at 10:02 AM and documented by RN C, reflected a skin tear to her right forearm. Review of Resident #1's progress notes, date 06/20/24 at 10:33 PM and documented by LVN A, reflected the following: Was called to [Resident #1] room by [CNA B] and informed there was abnormalities in the peri-area of the [Resident #1]. When assessed the peri area this nurse noted a hematoma, dark bruising to the vaginal area and right rear buttock, noted swelling to the area . Review of Resident #1's EMR, on 06/25/24, reflected a skin assessment was not completed after the finding of the hematoma to her vaginal area. Review of Resident #1's ER records, dated 06/23/24, reflected pictures of bruising to her body. The pictures revealed a dark purple bruise to her left medial thigh, dark bruising to her groin and pelvis area with swelling of her left labia, and dark bruising to her buttocks/perineum. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/25/24 at 11:03 AM, LVN A stated he was notified of Resident #1's hematoma to her vaginal area in the evening of 06/20/24 by CNA B. He stated he assessed her and noted there to be bruising to the pubis and vaginal area running towards the left buttock. He stated when his shift started earlier in the afternoon, he was informed by LVN D that she had a fall earlier that morning. He stated he attributed the bruising to the fall, thinking she may have hit or landed on something. He stated that was the only assumption he had. He stated he did notify the NP and DON. He stated he did not complete a full-body skin assessment because he was more concerned at ensuring she was not in pain. He stated he administered her PRN morphine. He stated neurological checks should have been conducted because she had the unwitnessed fall but he could not remember if he conducted them. He stated they should be documented in the resident's chart - every 15 minutes x4, then every 30 minutes x4, then every 8 hours x4. He stated the duration of the checks should be three days. During an interview on 06/25/24 at 11:25 AM, LVN D stated she worked from 6:00 AM - 2:00 PM on 06/20/24. She stated she was told by LVN C at shift change that Resident #1 had a fall earlier that morning but did not mention any injuries. She stated she could not remember if she conducted all necessary neurological checks but believed she did. She stated checks should be done every 15 minutes x3, then every 30 minutes x4, every hour x4, then every 8 hours. She stated the during should last about three days or so. She stated neurological checks were important to ensure there was not a change in mental status or speech. During an interview on 06/25/24 at 12:02 PM, the NP stated after an unwitnessed fall, neurological checks should be conducted based on facility protocol and the staff should be on top of it. She stated a negative outcome of not conducting the checks appropriately was hard to answer. During an interview on 06/25/24 at 1:55 PM, the DON stated she was notified of the hematoma to Resident #1's vaginal area on 06/21/24. She stated the NP assessed her that day and ordered x-rays. She stated she did not assess Resident #1 herself. She stated she did not realize a skin assessment had not been done when LVN A assessed her and it was her expectation that he would have completed a full-body assessment. She stated skin assessments were important to monitor all of the injuries and to be able to monitor and treat them appropriately. She stated not conducting skin assessments was not the standard of care here. She stated it was unacceptable for all neurological checks to not be completed after an unwitnessed fall. She stated they should be documented in the resident's EMR for 72 hours - every 15 minutes x4, every 30 minutes x4, every one-hour x4, every 8 hours x4, then once a day. Review of a facility in-serviced entitled Neurological Assessments, dated 06/24/24 and conducted by the DON, reflected nurses were in-serviced on their Neurological Assessment Policy. Review of the facility's Neurological Assessment Policy, Revised October of 2010, reflected the following: 1. Neurological assessments are indicated: a. Upon physician order; b. Following an unwitnessed fall . . Perform neurological checks with the frequency as ordered per falls protocol. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's Assessing Falls and Their Causes Policy, revised July of 2023, reflected the following: .After a Fall: .6. Observe for delayed complications of a fall for approximately Seventy Two (72) hours after an observed or suspected fall, and will document findings in the medical record.