STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455961	A. Building B. Wing	08/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Pinto Nursing Center	200 Southwest 25th Ave Mineral Wells, TX 76067

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observation, interview and record review the facility failed to ensure residents had a safe, clean, comfortable and homelike environment which included but not limited to receiving treatment and supports for daily living safely for 2 of 4 residents (Resident #43 and #18) reviewed for a homelike environment. 1. The facility failed to ensure Resident #43's room didn't have food debris, hair and trash under his bed. 2. The facility failed to ensure Resident #43's room window blinds and ledges were dusted or clean. 3. The facility failed to ensure Resident #18's window ledge and blinds were dusted. These failures could place residents at risk for an unsanitary, unhomelike environment, and a diminished quality of life. Findings include: 1. Record review of Resident #43's face sheet, dated 08/25/2024, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #43 had diagnoses which included type 2 diabetes (high blood sugar), hypertension (high blood pressure) and stroke. Record review of Resident #43's Quarterly MDS, dated [DATE], Section B- Hearing, Speech, and Vision, reflected he had highly impaired vision and a BIMS score of 15, which indicated cognitively intact cognition. Record review of Resident #43's care plan reflected he had impaired visual function, dated 05/22/2024, required assistance with activities of daily living, dated 05/20/2024, and had a surgical wound to his left food and was at risk of infection, dated 06/17/2024. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/20/2024 at 11:23 AM revealed the floor had crumbs of food, black and brown debris, and hair on the floor. Under Resident #43's bed revealed there was an opened white paper bag, the size of a paper lunch bag, laid on its side, under the head of his bed. The paper bag had a dried, brown water mark along the side of the bag and there were crumbs of food, a small plastic cup, and hair under his bed. The window ledge next to Resident #43's bed had a layer of dust and food debris. Interview on 08/20/2024 at 11:24 AM with Resident #43 revealed he was seated in a wheelchair in his room with the television on, there was a fly around his head. Resident #43 stated he thought housekeeping did a good job and he did not see the food or debris on the floor or under his bed and he complained the television did not have color. Observation of the television revealed it was in color. Observation and interview on 08/21/2024 at 9:04 AM of Resident #43's room with Housekeeper W revealed the debris and paper bag were still under Resident #43's bed and the window ledge and on the floor. Housekeeper W stated he had worked at the facility for about 3 months and was trained on cleaning resident rooms daily and had not been fully trained on deep cleanings. Housekeeper W stated he did not mop resident floors if they looked shiny and did not use the broom to sweep before he mopped the floor. Housekeeper W stated he used the mop head to sweep debris. Housekeeper W looked under Resident #43's bed and stated he observed the bag, debris, and hair under the bed and he did not look under the bed the previous day. Housekeeper W stated he did not typically look under the resident's beds. Housekeeper W observed Resident #43's window ledge and stated he did not clean the window ledges and was not sure if they were supposed to be completed during the everyday cleaning routine or during deep cleans. Housekeeper W stated he was supposed to move resident items and bedside tables when he cleaned and did not because he was worried residents would be upset he touched their things. Housekeeper W stated he was going to clean Resident #43's room shortly. Observation on 08/21/2024 at 04:09 PM of Resident #43's room revealed under his bed was not cleaned, the bag under the bed was removed and there was still debris under the bed and dust and residue on the windowsill remained the same, there were 2 flies in the room. Interview and observation on 08/21/24 at 04:17 PM with the Housekeeping Supervisor revealed Resident #43's room had food debris on the floor and under his bed, and the window blinds and sill had not been dusted. The Housekeeping Supervisor stated housekeepers cleaned resident rooms daily and were expected to dust the blinds and window ledges and sweep and mop the floors which included under the beds. 2. Record review of Resident #18's face sheet, dated 08/24/2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #18 had diagnoses which included stroke, dementia (loss of cognition), and hypertension (high blood pressure) and paraplegia (paralysis of the legs and lower body). Record review of Resident #18's Comprehensive MDS, dated [DATE], reflected she had a BIMS score of 15, which indicated intact cognition. Record review of Resident #18's care plan reflected she required assistance with activities of daily living due to paraplegia (paralysis of the legs and lower body), dated initiated 11/23/2021. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/20/24 at 11:14 AM with Resident #18 revealed housekeeping did not clean her room well. She stated they did not sweep her room daily and sometimes would just come in and only take the trash out. Resident #18 stated having a clean room was important to her because it was not sanitary. Observation and interview on 08/21/24 at 04:58 PM with the Housekeeping Supervisor of Resident #18's room revealed the window blinds and ledges were not dusted and there were thick cobwebs between the blinds and the window. The Housekeeping Supervisor stated the window blinds and window ledge were not dusted and the window ledge had dust and cobwebs and were supposed to be dusted every day by the housekeeping staff. He stated Housekeeper W should have cleaned the window ledge and blinds. He stated that it was important to clean the window areas for sanitation reasons and to ensure residents resided in a clean environment. Interview on 08/21/24 at 5:00 PM with Resident #18 revealed sometimes it seemed like they did not clean the floor at all and never saw housekeeping sweep or dust the window blinds or ledge. Resident #18 stated she complained to the Housekeeping Supervisor about her concern because it bothered her and he told her that he would address her concern with the housekeeping staff. Interview on 08/24/24 at 3:09 PM with the Housekeeping Supervisor revealed all housekeeping staff received 3 days of training where they shadowed a housekeeper, were shown what tasks to perform, took turns completing the tasks, and then cleaned on their own. He stated housekeeping staff were assessed once a year and he performed random checks of resident rooms to ensure they were being cleaned properly. He stated Housekeeper W did not have a performance review because he was new and did not have any random checks documented for him. He stated he believed the rooms were not cleaned properly because Housekeeper W was a newer employee and required more training. He stated Residents #43 and #18's rooms had not been cleaned properly and it was important to clean resident rooms properly because it was the frontline of infection control and residents deserved to live in a clean room. Interview on 08/25/24 at 06:15 PM with the Administrator revealed she was aware there were some housekeeping complaints. She stated her expectation was the resident rooms and common areas were cleaned thoroughly and there was a monthly deep clean schedule for resident rooms. She stated it was important resident rooms were cleaned properly because they were the resident's home and for infection control. She stated housekeeping services were through a contract company and they did not have a policy for cleaning resident rooms. She provided the policy for resident rights. Record review of the facility's resident rights policy titled, Resident Rights, dated 02/23/2016, reflected .8. The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview and record review the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and procedures to investigate any such allegations for one of six residents (Resident #24) reviewed for abuse and neglect. The facility failed to follow their policy for abuse and neglect by not reporting an allegation of neglect within 2 hours when HA (non-certified) C transferred Resident #24, without any assistance, for toileting. On [DATE] HA C transferred and toileted Resident #24 without any assistance. When transferring the resident from the toilet to the wheelchair, HA C heard a loud pop sound, and the resident was not able to stand. The HA C lowered the resident to the floor. As a result of the transfer, Resident #24 sustained a fracture of left femur. Resident #24 required a surgical intervention. Resident #24 was required to be non-weight bearing and have brace to the left leg after the incident This failure could place residents at risk for not having their allegations of abuse and neglect investigated. Findings include: Record review of the facility's policy titled, Abuse, Neglect and Exploitation, dated [DATE], reflected, .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility's Abuse Prevention Coordinator is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies . within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . Record review of Resident #24's Comprehensive MDS assessment dated [DATE] reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included cerebral infarction (damage to the brain from interruption of its blood supply), dysphagia (difficulty swallowing), and hemiplegia and hemiparesis (partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). Resident #24's BIMS was 15, which indicated her cognition was intact. The MDS assessment indicated Resident #24 required extensive assistance of one-person physical assistance with transfer, and personal hygiene. GG functional section reflected the resident required substantial /maximal assistance with toilet transfer. Record review of Resident #24 care plan dated [DATE] reflected: Focus: Fall - [Resident #24] has the potential for falls related to . Gait/balance. Goal: The resident will be free of falls through the next review date. Interventions: Transfers with assist of 2 staff. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Resident #24's Nurses Notes completed by LVN D and dated [DATE] reflected, . I was called to her room and found her lying in the bathroom floor. HA C stated she was transferring her back to wheelchair when there was a loud pop and she wasn't able to stand, HA C then lowered her to floor and got me. Left leg and foot were turned inward. Action: I notified DON and Doctor . Resident was transferred to the hospital . Review of Resident #24's hospital records, dated [DATE], reflected the following: .Female who presented to the emergency department from nursing home after a fall which occurred at the skilled nursing facility. She stated that she was using the commode when her left leg gave way and she fell . She began to experience pain in the left leg. She had imaging studies done at the local emergency department which revealed a complex comminuted fracture of the distal femur with mild displacement. She was therefore sent here for further management. Pre operation diagnoses: Left extra-articular distal femur fracture. Procedure: Intramedullary nailing of left distal femur fracture. During the course of the patient's operation, surgical assistance was provided. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, elevated blood pressure, and osteoarthritis. Resident #56's BIMS score was 15, which indicated his cognition was intact. In an interview on [DATE] at 9:25 AM, Resident #56 (Resident #24's Family Member living with Resident #24 in the same room), stated on [DATE] HA C assisted Resident #24 to the toilet without help of another staff. He stated usually 2 staff helped Resident #24 with transfer. Resident #56 stated HA C went in to help Resident #24 get off the toilet. When she helped get her up and turned her to the wheelchair for the transfer, her knees gave out and there was a loud pop as she was lowered to the ground. Resident #56 stated he yelled for help and the nurse and other staff came in for help, somebody called the ambulance and Resident #24 was sent to the hospital. In an interview on [DATE] at 9:30 AM, Resident #24 stated HA C dropped her on the floor in the toilet. Resident #24 stated usually 2 people transferred her before and after the incident of [DATE]. In an interview on [DATE] at 2:42 PM, LVN D stated she was working the evening of the incident when she heard Resident #24's Family Member calling for help in the room. LVN D stated when she walked in, the resident's leg was turned outward and looked to be broken. LVN D stated she assessed the resident. Another staff called the 911. Resident #24 was transferred to the hospital. LVN D stated Resident #24 is 2 persons assist with transfer. LVN D stated hospitality aides were not allowed to transfer residents. LVN D stated she called the DON to notify him about the incident. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 3:17 PM, HA C stated on [DATE] at approximately 9 PM she reported to Resident #24's room, resident needed to go to the restroom. HA C stated she assisted Resident #24 to the toilet. When transferring the resident from toilet back to wheelchair, resident used grab bars to assist in standing up, HA C assisted resident with pulling up pants, in the middle of turning the resident's left knee buckled, HA C instructed the resident to try and stand up. Resident #24 reported she could not. HA C stated she heard a loud pop and assisted resident to the floor. Resident #56 called for assistance, the nurse and staff member reported to resident's room. HA C confirmed she was not a CNA (her certificate was expired since 2014), and stated she had to work with a certified nurse aide on the floor at all times. At the time of this interview HA C stated she had received an in-service on transfers of Resident #24 after the fall occurred on the evening of [DATE]. HA C stated she assisted Resident #24 to the toilet without assistance because the CNA was break. She stated she supposed to call the nurse because Resident #24 needed 2 persons for transfer. She stated she never transferred Resident #24 before, because as a HA she was not allowed to transfer Resident #24 or any other resident. In an interview with the DON on [DATE] at 3:30 PM, he stated hospitality aides were not allowed to provide any direct care to residents. He stated HA C should not transfer Resident #24. He stated if the CNA was not available the HA C should notify the nurse about Resident #24 needs. He stated hospitality aides were in-serviced on job description up on hire. The DON did not provide the in-service on job description for HA C to the surveyor. The DON stated Resident #24 was 2 persons assist with transfer. The DON stated the amount of assistance needed by a resident would be reflected in the Kardex system for nursing staff. The surveyor asked if the care plan populated the Kardex because the Kardex did not show before and after the incident that Resident #24 was a two-person assist for transfer. The DON stated he was, and the ADONs, responsible to oversee the care plans for updates and the Kardex to reflect the care plans. The DON stated charge nurses, ADONs himself did routine rounds to monitor to ensure transfers were being done appropriately. The DON stated the incident was discussed with the Administrator and the corporation staff, and it was determined not to report. In an interview with the Administrator on [DATE] at 4:35 PM, she stated she was notified on [DATE] by the DON of the incident that had occurred on [DATE]. The Administrator stated the incident was discussed with the corporation staff and it was determined not to report because the fall was witnessed, and the origin of the injury was known. The surveyor reviewed the provider letter with the Administrator, the Administrator determined that the incident was supposed to be reported to the state agency and investigated as an allegation of neglect because of the serious injury. The Administrator stated she would report the incident to the state agency. Record review of the Provider Investigation report for resident #24 dated [DATE] reflected, .Incident date [DATE] at 8:30 PM .description of incident .Resident was being transferred by a non-certified aide and sustained an injury.Nurse assessed resident and noticed evidence of fracture. Resident was transported to hospital by EMS . HA C was suspended. MD and RP notified. Safe survey completed. In-service regarding abuse and neglect and fall prevention .Skin assessment performed on all resident who are unable to be interviewed. Staff educated regarding transfers . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow u interview with the Administrator on [DATE] at 6:15 PM revealed she had been in-serviced on abuse/neglect policy and reporting requirements. She was knowledgeable of the facility policy including abuse and neglect definitions and reporting requirements as the abuse coordinator. She stated the facility's investigation into the incident findings was neglect and the Hospitality Aide should not have been transferring the resident or providing any direct care to the resident. She stated the Hospitality Aide involved in the incident was suspended and had not returned back to work at the facility. She stated all the hospitality aides have now been signed up for a class in [DATE] so they can work towards getting their nurse aide certification. She stated as the abuse coordinator she should have reported the neglect allegation with major injury within 2 hours to the state from notification of resident sustaining a fracture, suspended the hospitality aide pending investigation, conduct an investigation of the incident and report the findings to the state. Record review of the facility's job description for a Hospitality Aide revised on [DATE] revealed: . Responsible for providing resident related (no-hands-on) care in accordance with quality standards under the direction of a licensed charge nurse. The position is applicable prior to successfully receiving certification as a nursing assistant. Performs host/hostess type duties in accordance with accepted standards of non-hands-on resident care. Uses daily task assignments. Assist residents that are independent and residents that require minimal or supervision support with activities of daily living, set up bed bath and rinse and soap wash cloth handing to patient. Lay out clothes, hold clothes in position patient can dress self, button clothes, pull up pants, changes unoccupied bed linens, answers call lights assist within skill level, passing and serving water. Assists with resident's recreation programs and transports residents in wheelchairs. Labels personal care items. Keeps resident rooms tidy. Maintains clothing inventory. Reports changes of resident condition to nurse in charge, reports accidents and incidents, and provides support functions as directed by supervisor.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 42971 49427 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive care plan to meet the highest practicable physical, mental, and psychosocial wellbeing for 2 (Resident #9 and #24) of 24 residents reviewed for care plans. 1. The facility failed to develop and implement a comprehensive care plan for Resident #24 to address the left femur fracture sustained on [DATE] and current transfer status. 2. The facility failed to update Resident #24's Kardex (a brief digital overview of the resident's needs) to reflect she required 2 people to transfer her. As a result, the resident was transferred on [DATE] by a hospitality aide. Resident #24 was sent to the hospital and sustained a femur fracture. 3. The facility failed to develop a comprehensive care plan for Resident #9 to address her non-compliance with asking for assistance with transfers and failed to follow Resident #9 transfer status. As a result, staff were not aware of the transfer status of Resident #9 and she experienced an unwitnessed fall on [DATE], [DATE], and [DATE]. 4. The facility failed to update Resident #9's care plan to address the nasal bone fracture on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:30 PM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a scope of pattern and severity level of potential for more than minimal harm because all staff had not been trained comprehensive care plans These failures could place residents at risk for not receiving care required to meet their individualized needs and place them at risk for falls and injury. Findings included: Resident #24 Record review of Resident #24's Comprehensive MDS assessment dated [DATE] reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included cerebral infarction (damage to the brain from interruption of its blood supply), dysphagia (difficulty swallowing), and hemiplegia and hemiparesis (partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). Resident #24's BIMS was 15, which indicated her cognition was intact. The MDS assessment indicated Resident #24 required extensive assistance of one-person physical assistance with transfer, and personal hygiene. GG functional section reflected the resident required substantial /maximal assistance with toilet transfer. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #24 care plan dated [DATE] reflected: Focus: Fall - [Resident #24] has the potential for falls related to . Gait/balance. Goal: The resident will be free of falls through the next review date. Interventions: Transfers with assist of 2 staff. Record review of the Post-Fall Risk assessment dated [DATE] revealed Change in Functional Ability . New Interventions: 2 persons lift with Hoyer. Review of the Provider Investigation report, dated [DATE], for Resident #24 reflected, .Incident date [DATE] at 8:30 PM .description of incident .Resident was being transferred by a non-certified aide and sustained an injury.Nurse assessed resident and noticed evidence of fracture. Resident was transported to hospital by EMS . HA C was suspended. MD and RP notified. Safe survey completed. In-service regarding abuse and neglect and fall prevention .Skin assessment performed on all resident who are unable to be interviewed. Staff educated regarding transfers . Review of the Nurses Notes completed by LVN D and dated [DATE] reflected, . I was called to her room and found her lying in the bathroom floor. HA C stated she was transferring her back to wheelchair when there was a loud pop and she wasn't able to stand, HA C then lowered her to floor and got me. Left leg and foot were turned inward. Action: I notified DON and Doctor. Resident was transferred to the hospital . Review of Resident #24's hospital records, dated [DATE], reflected the following: .Female who presented to the emergency department from nursing home after a fall which occurred at the skilled nursing facility. She stated that she was using the commode when her left leg gave way and she fell . She began to experience pain in the left leg. She had imaging studies done at the local emergency department which revealed a complex comminuted fracture of the distal femur with mild displacement. She was therefore sent here for further management. Pre operation diagnoses: Left extra-articular distal femur fracture. Procedure: Intramedullary nailing of left distal femur fracture. During the course of the patient's operation, surgical assistance was provided. Record review of Resident #24's care plan dated [DATE] did not reflect the fall with the facture and did not reflect the new intervention of 2 persons lift with Hoyer. Record review of Resident #24's MDS Kardex report, dated [DATE], revealed Resident Care . Transfers: Extensive 1 staff . Toileting: Extensive assist 1 staff. In an interview on [DATE] at 9:25 AM, with Resident #56 revealed he was in Resident #24's room during the incident on [DATE]. He stated HA C assisted Resident #24 to the toilet without help of another staff. He stated usually 2 staff helped Resident #24 with transfer. Resident #56 stated HA C went in to help Resident #24 get off the toilet. When she helped get her up and turned her to the wheelchair for the transfer, her knees gave out and there was a loud pop as she was lowered to the ground. Resident #56 stated he yelled for help and the nurse and other staff came in for help, somebody called the ambulance and Resident #24 was sent to the hospital. In an interview on [DATE] at 9:30 AM, Resident #24 stated HA C dropped her on the floor in the toilet. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 2:42 PM, LVN D stated she was working the evening of the incident when she heard Resident #24's Family Member calling for help in the room. LVN D stated when she walked in, the resident's leg was turned outward and looked to be broken. LVN D stated she assessed the resident. Another staff called the 911. Resident #24 was transferred to the hospital. LVN D stated Resident #24 is 2 persons assist with transfer. LVN D stated hospitality aides were not allowed to transfer residents. In an interview on [DATE] at 3:17 PM, HA C stated on [DATE] at approximately 9 PM she reported to Resident #24's room, resident needed to go to the restroom. HA C stated she assisted Resident #24 to the toilet because the CNA was on break. HA C stated she was able to access the Kardex. When transferring the resident from toilet back to wheelchair, resident used grab bars to assist in standing up, HA C assisted resident with pulling up pants, in the middle of turning the resident's left knee buckled, HA C instructed the resident to try and stand up. Resident #24 reported she could not. HA C stated she heard a loud pop and assisted resident to the floor. Resident #56 called for assistance, the nurse and staff member reported to resident's room. HA C confirmed she was not a CNA (her certificate was expired since 2014), and stated she had to work with a certified nurse aide on the floor at all times. At the time of this interview HA C stated she had received an in-service on transfers of Resident #24 after the fall occurred on the evening of [DATE]. HA C stated she assisted Resident #24 to the toilet without assistance because the CNA was break. In an interview with the DON on [DATE] at 3:30 PM, he stated hospitality aides were not allowed to provide any direct care to residents. He stated HA C should not transfer Resident #24. He stated hospitality aides were in-serviced on job description up on hire. The DON did not provide the in-service on job description for HA C to the surveyor. The DON stated Resident #24 was 2 persons assist with transfer. The DON stated the amount of assistance needed by a resident would be reflected in the Kardex system for nursing staff. The surveyor asked if the care plan populated the Kardex because the Kardex did not show before and after the incident that Resident #24 was a two-person assist for transfer. The DON did not provide any answer. The DON stated he was, and the ADONs, responsible to oversee the care plans for updates and the Kardex to reflect the care plans. Resident #9 Record review of Resident #9's face sheet, printed date [DATE], revealed she was a [AGE] year-old female initially admitted on [DATE], and readmitted on [DATE] with diagnoses of fracture of nasal bones, metabolic encephalopathy (metabolic disorder), sepsis (life threatening complication of infection), muscle weakness, repeated falls, type-2 diabetes (high blood sugar), congestive heart failure, major depressive disorder (persistent feelings of sadness or loss of interest), chronic obstructive pulmonary disease (lung disease causing restricted airflow), and anxiety disorder (persistent feelings of worry or fear). Record review of Resident #9's Quarterly MDS, dated [DATE], revealed she required partial/moderate assistance for transfers, and she had a BIMS score of 15 (intact cognition). Review of Resident #9's MDS Kardex report, undated, revealed she required setup help and supervision for transfers and was not steady when moving from seated to standing, moving on and off the toilet, or with surface-to-surface transfers and the section for accidents and fall risk was blank. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Pinto Nursing Center	200 Southwest 25th Ave Mineral Wells, TX 76067

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #9's care plan revealed there were functional limitations in range of motion or decreased mobility, impaired balance and impaired coordination, dated initiated and revised on [DATE]. Interventions included her transfer status was limited x 1 dated initiated [DATE] and revised [DATE]. Review revealed Resident #9 had the potential for falls related to incontinence, gait/balance problems and was unaware of safety needs, dated initiated [DATE] and revised on [DATE]. Interventions included educate resident to let staff know when she was going to the bathroom so they could check on her date initiated, [DATE]; medication review to be performed by psych for fall eval, dated initiated [DATE]; Resident #9's care plan did not reflect she had a fall on [DATE], [DATE] with fracture, or [DATE]. Review of the incident report dated [DATE] at 9:40 PM, completed by LVN U, revealed Resident #9 had an unwitnessed fall. Resident #9 was found sitting on the floor in the bathroom and stated she had fallen asleep on the toilet and then had fallen and bumped her head and left shoulder on the wall and floor. LVN U assessed Resident #9 for injuries and there were none observed, range of motion was normal, she complained of pain to her left shoulder, displayed no visual signs of pain, and was assisted into her wheelchair and into bed. Review of the incident report dated [DATE] at 2:05 AM completed by RN DD, revealed Resident #9 had an unwitnessed fall. RN DD was called to Resident #9's room by a CNA and witnessed Resident #9 was on her stomach on the floor beside her bed with a considerable amount of blood coming from a laceration above the right eyebrow and from her nose. Resident #9 had urinated in her bed and appeared to have gotten out of bed and fell on her stomach and face. RN DD called 911 and Resident #9 was taken to the hospital around 2:30 AM. Review of Resident #9's hospital visit documentation, dated [DATE] revealed she was seen for a nasal bone fracture, laceration of face, and forehead contusion. Review of Resident #9's the CT report dated [DATE] at 5:26 AM revealed she had a comminuted displaced bilateral nasal fractures (multiple broken nasal bones) and right facial and nasal swelling with lacerations. Review of the Post-Fall Evaluation dated [DATE] at 11:18 AM and signed by ADON A revealed Resident #9 had no falls within the last 6 months and had incontinence and decline in ability due to COVID-19 and was added to incontinent rounds and placed on 2-hour checks for assistance toileting. Review of the progress notes dated [DATE] at 7:02 AM by RN DD revealed Resident #9 returned from the hospital at 6:35 AM with Dermabond to the bridge of her nose laceration (cut), contusion (bruising) to forehead, and multiple nose fractures (broken nasal bones) with no deviations (deformity). Review of the Post-Fall Evaluation dated [DATE] at 1:04 PM by RN I revealed Resident #9 had a fall from the toilet and was instructed to use her call light for transfers. The root cause analysis indicated the resident was sleepy and did not use her call light and resident was educated on need for increased help while recovering from COVID-19. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the incident report dated [DATE] at 3:25 AM by LVN U revealed Resident #9 had an unwitnessed fall and was found face down on the floor in her bathroom and was not able to respond to verbal commands or conversation and was unable to describe what happened or to lift up her head. Resident #9 was placed on a swing so she would be lifted to the stretcher and the paramedics transported her to the hospital. LVN U stated that Resident #9 complained of pain to the top of her head. Review of Resident #9s hospital visit documentation, dated [DATE] revealed she had no fractures. Review of Resident #9's Physical Therapy evaluation and plan of treatment dated [DATE] revealed she was referred to physical therapy services due to having 2 falls in one week after having COVID-19. Resident #9's previous level of function with transfers was moderately independent and she currently required minimal assistance. The evaluation revealed Resident #9 had fallen 2 times in the past year, had an injury of bruising to face and toes, felt unsteady while standing, walking, and worried about falling. Review of Resident #9's Occupational Therapy Evaluation and Plan of Treatment dated [DATE] revealed she was referred to occupational therapy due to a new onset of COVID-19 with two recent falls that resulted in a significant number of contusions to her face and elsewhere on her body and a fracture of her nose with a recent fall. Resident #9 had a decrease in strength, functional mobility, transfer ability, reduced functional activity tolerance, reduced static and dynamic balance, decreased judgment, increased need for assistance from others, reduced ADL participation and pain. She required minimal assistance with toilet transfers. Observation and interview on [DATE] at 10:28 AM with Resident #9 revealed she was seated in her power wheelchair in her room and had dark purple, brown, and yellow, bruises around her eyes, nose, and cheeks and medical tape on the bridge of her nose. She stated she had a fall two weeks prior, she broke her nose when she fell out of bed when she attempted to transfer herself to her wheelchair. She stated she had another fall on [DATE] when she fell asleep on the toilet and fell and hit her head which resulted in a big bump on her head. She stated that she did not have a prior history of falls before and thought it was due to taking melatonin and had requested it be discontinued. She stated that she was able to transfer herself, did not need staff assistance, and staff were responsive to her when she asked for assistance. Interview on [DATE] at 11:42 AM with CNA K revealed she was familiar with Resident #9 and was not working the day she fell and broke her nose or when she hit her head. She stated that Resident #9 was independent and required verbal cueing during toileting but did not require any physical assistance during transfers. She stated that Resident #9 did not refuse care and they got along well. Interview on [DATE] at 1:11 PM with CNA X revealed she was familiar with Resident #9. She stated Resident #9 was independent and used her call light to ask for assistance. She stated that she worked the day before Resident #9 fell and broke her nose. CNA X stated that after Resident #9 returned from the hospital she was incontinent and was required to stay in bed for a short time. CNA X stated she was currently unsure what level of assistance Resident #9 required with transfers and would typically ask CNA K if she had questions. CNA X stated that Resident #9 only required standby assistance when toileting. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 1:49 PM with RN I revealed Resident #9 was independent and she was not working when she had the fall where she hit her head or broke her nose. She stated that after Resident #9 returned from the fall where she broke her nose, she was a two person assist, and now only required standby assistance. Interview on [DATE] at 3:07 PM with the MDS Coordinator revealed she had worked at the facility for less than a month. She stated she was responsible for completing MDS assessments that included the annual and quarterly MDS, which reflected a resident's abilities and needs. She stated that there was a look back period of 7 days where the IDT submitted their assessments of the resident's abilities, and the most severe or limited rating was entered into the system. The MDS Coordinator was shown Resident #9's MDS, dated [DATE], and she stated she was not sure what the number 3- partial/moderate assistance level meant and reviewed the legend. She stated that it might mean that they needed some sort of assistance such as putting on their shirt or cueing with touch. She stated for bed transfers a partial/moderate assistance coding might mean that they required verbal cuing, or light touch cuing. Interview on [DATE] at 3:24 PM with the Rehabilitation Director revealed he was familiar with Resident #9 and she was started on physical therapy and occupational therapy services on [DATE]. He stated that she was previously on physical and occupational therapy services in [DATE], and she was discharged on [DATE] due to not participating consistently. He stated upon discharge from therapy services she was able to transfer independently. He stated that after she had a fall where she broke her nose, they did not discuss bringing her back onto therapy services because of her previous refusals and she required minimal assistance with transfers which meant one person with a gait belt. Interview on [DATE] at 3:57 PM with ADON A revealed Resident #9 was fairly independent and her goal was to move into the community, so they tried to encourage her to be independent. ADON A stated that she was not sure what the MDS partial/moderate assistance meant, and she looked at the Kardex to find a resident's transfer status and the nurses informed each other of changes of condition during morning meetings. Interview on [DATE] at 4:10 PM with LVN U revealed on [DATE] she responded to Resident #9's call light and she was sitting on the floor of the bathroom. She stated Resident #9 told her that she fell asleep on the toilet and hit her head and shoulder on the wall. She stated on [DATE] she was called to the Resident's room by the roommate and Resident #9 had fallen off of the toilet and had an injury to the top of her head and was not responsive, so she was sent to the hospital. LVN U stated she was not working on [DATE] when resident fell and broke her nose. She stated that the MDS was accurate and reflected she required partial/moderate assistance with transfers and Resident #9 used to be able to transfer herself safely. Interview on [DATE] at 6:00 PM with the DON revealed Resident #9's had a history of falls, and they were care planned. The DON stated Resident #9 had never had a fracture before and was noncompliant with medication and care. He stated he was responsible for care plans and Resident #9's noncompliance might not be documented under falls but was documented under other care areas and was also noted in the progress notes. The DON stated that Resident #9 was able to transfer independently, and they discontinued the melatonin medication. The DON stated that he did not remember if he did an in-service with staff because they did what they were supposed to do, and she was able to tell them what happened. The DON stated that Resident #9 was previously on physical and occupational therapy services and was discontinued due to noncompliance and started again recently. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 6:09 PM with the Administrator revealed Resident #9 had more falls lately and they thought it was due to medications such as melatonin made her drowsier. The Administrator stated that Resident #9 had a high BIMS score and was able to tell them what happened and did not do an in-service regarding her fall. Record review of facility's policy titled, Transfers of Residents, dated reviewed [DATE] reflected .The goal is to ensure the safety of the resident when moving from one place to another, to prevent injuries to the resident, to prevent injuries to staff member assisting the resident, and to enable the resident to as independent during the transfer as possible . Record review of facility's policy titled, Comprehensive Care Plans, dated [DATE], reflected It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment . will be prepared by an interdisciplinary team .The facility will attempt alternate methods for refusal of treatment and services and document such attempts in the clinical record, including discussions with the resident and/or resident representative . Record review of the facility's job description for a Hospitality Aide revised on [DATE] revealed: . Responsible for providing resident related (no-hands-on) care in accordance with quality standards under the direction of a licensed charge nurse. The position is applicable prior to successfully receiving certification as a nursing assistant. Performs host/hostess type duties in accordance with accepted standards of non-hands-on resident care. Uses daily task assignments. Assist residents that are independent and residents that require minimal or supervision support with activities of daily living, set up bed bath and rinse and soap wash cloth handing to patient. Lay out clothes, hold clothes in position patient can dress self, button clothes, pull up pants, changes unoccupied bed linens, answers call lights assist within skill level, passing and serving water. Assists with resident's recreation programs and transports residents in wheelchairs. Labels personal care items. Keeps resident rooms tidy. Maintains clothing inventory. Reports changes of resident condition to nurse in charge, reports accidents and incidents, and provides support functions as directed by supervisor. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 12:30 PM. The Administrator, DON, and Regional Nurse Consultant were notified. The Administrator was provided with the IJ template on [DATE] at 12:30 PM. The Immediate Jeopardy plan of removal was accepted on [DATE] at 6:05 PM and the Regional Nurse Consultant was notified of the acceptance. Immediate Jeopardy Removal Plan: Issue Cited: The facility failed to develop and implement a comprehensive care plan for Resident # 24 to address the left femur fracture sustained on [DATE] The facility failed do develop a comprehensive care plan for resident # 9 to address the nasal bone fracture and failed to follow resident # 9 transfer status 1. Immediate Action Taken (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A. On [DATE] the MDS nurse/Designee completed a comprehensive care plan for resident # 24 to address left femur fracture, and falls care plan to reflect appropriate interventions. This was completed [DATE] B. On [DATE] the MDS nurse/Designee completed an acute care plan for resident # 9 to address the nasal bone fracture, update the fall care plan to reflect appropriate interventions and resident # 9 right to refuse care with education provided at each point of contact. This was completed [DATE] C. On [DATE] a review of resident # 9 and resident # 24 care plan and Kardex was reviewed by Regional Reimbursement Consultant and validated that the care plan was accurate. This was completed on [DATE] D. On [DATE] the Regional Nurse consultant provided education to the MDS nurse on completion of, correct and timely care plan interventions, and that appropriate intervention(s) is reflective on the Kardex to include Activities of Daily Living. This was completed on [DATE]. The Regional Reimbursement Nurses will provide oversight on this process weekly x 4 weeks. E. On [DATE] the Regional Nurse consultant provided 1:1 education to the center's DON on care plan policy which defines the responsibility of the DON to complete acute care plans within 48 hours and with appropriate interventions, and that if applicable, the intervention(s) are reflective on the C.N.A. Kardex. This was completed on [DATE] at 12:00 pm. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks F. On [DATE] the Regional Nurse consultant provided 1:1 education to the center's MDS nurse that reflects that the MDS nurse is responsible for weekly care plan reviews, and that completed MDS's (ADL section) is correct on the ADL care plan, and that the resident's ADL's flow over to C.N.A. Kardex. This was completed on [DATE]. The Regional Reimbursement nurse will provide oversight on this process weekly x 4 weeks. 2. Identification of Residents Affected or Likely to be Affected: A. On [DATE] the Regional Reimbursement Nurse and MDS nurse conducted 100% audit of all residents MDS regarding ADL's. MDS nurse and Regional Reimbursement Consultant then validated that the ADL's coded on the MDS was accurate on each resident's care plans that the ADL's from each resident's care plan flowed over to the C.N. A. Kardex. This was completed on [DATE] and the Regional Reimbursement Consultant will provide oversight on this process weekly x 4 weeks. 3.Actions to Prevent Occurrence/Recurrence: o MDS nurse or Designee will review all residents with changes of conditions, including transfers, falls, daily in the morning meeting and will review/revise care plans as needed. o The Weekend Supervisor or Designee will review all residents with changes of conditions, including transfers, falls, on weekends and will review/revise care plans as needed On [DATE] the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related Comprehensive Care Plans and reviewed plan to sustain compliance (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] the facility conducted and Ad Hoc QAPI meeting to discuss Care Plans and on sustaining compliance. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: _____[DATE] Monitoring for Plan of Removal: Record review of the MDS in-service, provided by Regional Nurse Consultant, dated [DATE], topic- MDS will be responsible for the completion of comprehensive, annual, and significant changes care plans in a timely manner to ensure the care et [and] services a resident will need signed by MDS Coordinator. Record review of the nursing management in-service, provided by Regional Nurse Consultant, dated [DATE], topic-care plans, Kardex, and activities of daily living signed by the DON, ADON A and ADON B. Record review of the nursing management in-service, provided by Regional Nurse Consultant, dated [DATE], topic- Transfer of Residents 1. Gait belt 2. Standby assist 3. Hoyer 4. Transfer residents according to Kardex with comes from the care plan signed by the DON, ADON A and ADON B. Record review of the in-service, provided by RN I, dated [DATE]- Topic Nursing Aides Kardex . direct all aides (CNA, NA, HA) to review Kardex for appropriate assistance needed per resident . aides are to review Q [every] shift prior to being of shift . aides are to provide care to resident according to Kardex signed by 6 Hospitality Aides (Hospitality Aide P, R, S, T, V), 1 CNA (CNA FF), and 2 LVN's (LVN O and Q). Observation and interview on [DATE] at 10:10 AM with Resident #9 revealed she was lying in bed watching television. She stated she self-transfers herself from the bed to the wheelchair and planned to get up in about an hour. She stated she would not need assistance and stated no one had spoken with her about transfers. Observation and interview on [DATE] at 10:25 AM of Resident #9's care plan with the DON revealed there was no updated care plan for resident assistance with transfers or refusing assistance. The DON stated he had not attempted to educate Resident #9 between [DATE] and [DATE] because he had educated her in the past multiple times. The DON stated that Resident #9's noncompliance with transfers had not been care planned and he was unable to find a recent progress note that showed she refused assistance with transfers. Interview on [DATE] at 10:55 AM with the Administrator and the DON revealed Resident #9 had been educated to ask for assistance during transfers and provided an updated care plan. Record review of Resident #9's updated care plan revealed she was non-compliant with transfers, date initiated [DATE] and interventions included education on allowing staff to assist with transfers and respect resident's wishes regarding transfers; had potential for injury due to use of electric wheelchair with interventions of physical therapy assessment, reassess as needed, report any incidents to therapy and doctor, date initiated [DATE]; had potential for complications related to fractured nose with interventions of follow orders for treatment and report any changes in condition regarding the fracture to the doctor, date initiated [DATE]; transfer status was to limited x 1, date initiated [DATE] and revised on [DATE]; use gait belt with transfers, date initiated [DATE]. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the nursing management in-service, provided by Regional Nurse Consultant, dated [DATE], topic-care plans, Kardex, and activities of daily living signed by the DON, ADON A and ADON B. Record review of the nursing management in-service, provided by Regional Nurse Consultant, dated [DATE], topic- Transfer of Residents 1. Gait belt 2. Standby assist 3. Hoyer 4. Transfer residents according to Kardex with comes from the care plan signed by the DON, ADON A and ADON B. Record review of in-service, provided by RN I, dated [DATE]- Topic Nursing Aides Kardex . direct all aides (CNA, NA, HA) to review Kardex for appropriate assistance needed per resident . aides are to review Q [every] shift prior to being of shift . aides are to provide care to resident according to Kardex signed by 6 Hospitality Aides (Hospitality Aide P, R, S, T, V), 1 CNA (CNA FF), and 2 LVN's (LVN O and Q). Observation on [DATE] at 1:45 PM of transfer of Resident #9 revealed she was seated in her wheelchair facing the bed at a 45-degree angle. ADON A was standing off to the side of Resident #9 and did not place a gait belt or prompt resident with a count down. Resident #9 stood up, stepped down from her wheelchair to the floor. ADON A placed her hand under Resident #9's elbow and Resident #9 turned and sat down on the bed. Resident #9 stayed seated for a minute and then stood up, leaned forward, and grabbed the handle of her wheelchair with her left hand, paused then stepped up onto her electric wheelchair and turned and sat down. ADON A assisted resident with her oxygen. Interview on [DATE] at 2:00 PM with the Regional Nurse Consultant revealed she was informed of ADON A's inappropriate transfer of Resident #9 and was going to reeducate ADON A immediately. Interviews on [DATE] between 3:14 PM - 3:30 PM with 5 Hospitality Aides (P, T, V, S, and R) revealed they [TRUNCATED]

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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** 42971 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision/assistance to prevent accidents for one (Resident #24) of four residents reviewed for accidents. The facility failed to ensure Resident #24 was free of accident hazard when HA (non-certified) C transferred Resident #24, without any assistance, for toileting. On [DATE] HA C transferred and toileted Resident #24 without any assistance. When transferring the resident from the toilet to the wheelchair, HA C heard a loud pop sound and the resident was not able to stand. The HA C lowered the resident to the floor. As a result of the transfer, Resident #24 sustained a fracture of left femur. Resident #24 required a surgical intervention. Resident #24 was required to be non weight bearing and have brace to the left leg after the incident. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 12:30 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of actual harm because the facility was still monitoring the effectiveness of the plan of removal. This failure could place residents at risk for accidents and harm. Findings included: Record review of Resident #24's Comprehensive MDS assessment dated [DATE] reflected Resident #24 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included cerebral infarction (damage to the brain from interruption of its blood supply), dysphagia (A condition that affects the ability to produce and understand spoken language), and hemiplegia and hemiparesis (partial paralysis on one side of the body that can affect the arms, legs, and facial muscles). Resident #24's BIMS was 15, which indicated her cognition was intact. The MDS assessment indicated Resident #24 required extensive assistance of one-person physical assistance with transfer, and personal hygiene. GG functional section reflected the resident required substantial /maximal assistance with toilet transfer. Record review of Resident #24 care plan dated [DATE] reflected: Focus: Fall - [Resident #24] has the potential for falls related to . Gait/balance. Goal: The resident will be free of falls through the next review date. Interventions: Transfers with assist of 2 staff. Review of the Provider Investigation report for Resident #24 dated [DATE] reflected, .Incident date [DATE] at 8:30 PM .description of incident .Resident was being transferred by a non-certified aide and sustained an injury.Nurse assessed resident and noticed evidence of fracture. Resident was transported to hospital by EMS . HA C was suspended. MD and RP notified. Safe survey completed. In-service regarding abuse and neglect and fall prevention .Skin assessment performed on all resident who are unable to be interviewed. Staff educated regarding transfers . (continued on next page)

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	455961	A. Building B. Wing	08/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Pinto Nursing Center	200 Southwest 25th Ave Mineral Wells, TX 76067

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Nurses Notes for Resident #24 completed by LVN D and dated [DATE] reflected, . I was called to her room and found her lying in the bathroom floor. HA C stated she was transferring her back to wheelchair when there was a loud pop and she wasn't able to stand, HA C then lowered her to floor and got me. Left leg and foot were turned inward. Action: I notified DON and Doctor . Resident was transferred to the hospital . Review of Resident #24's hospital records, dated [DATE], reflected the following: .Female who presented to the emergency department from nursing home after a fall which occurred at the skilled nursing facility. She stated that she was using the commode when her left leg gave way and she fell . She began to experience pain in the left leg. She had imaging studies done at the local emergency department which revealed a complex comminuted fracture of the distal femur with mild displacement. She was therefore sent here for further management. Pre operation diagnoses: Left extra-articular distal femur fracture. Procedure: Intramedullary nailing of left distal femur fracture. During the course of the patient's operation, surgical assistance was provided. Record review of Resident #56's Quarterly MDS assessment dated [DATE] reflected Resident #56 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, elevated blood pressure, and osteoarthritis. Resident #56's BIMS score was 15, which indicated his cognition was intact. In an interview on [DATE] at 9:25 AM, Resident #56 (Resident #24's Family Member living with Resident #24 in the same room), stated on [DATE] HA C assisted Resident #24 to the toilet without help of another staff. He stated usually 2 staff helped Resident #24 with transfer. Resident #56 stated HA C went in to help Resident #24 get off the toilet. When she helped get her up and turned her to the wheelchair for the transfer, her knees gave out and there was a loud pop as she was lowered to the ground. Resident #56 stated he yelled for help and the nurse and other staff came in for help, somebody called the ambulance and Resident #24 was sent to the hospital. In an interview on [DATE] at 9:30 AM, Resident #24 stated HA C dropped her on the floor in the toilet. Resident #24 stated usually 2 people transferred her before and after the incident of [DATE]. In an interview on [DATE] at 2:42 PM, LVN D stated she was working the evening of the incident when she heard Resident #24's Family Member calling for help in the room. LVN D stated when she walked in, the resident's leg was turned outward and looked to be broken. LVN D stated she assessed the resident. Another staff called the 911. Resident #24 was transferred to the hospital. LVN D stated Resident #24 is 2 persons assist with transfer. LVN D stated hospitality aides were not allowed to transfer residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 3:17 PM, HA C stated on [DATE] at approximately 9 PM she reported to Resident #24's room, resident needed to go to the restroom. HA C stated she assisted Resident #24 to the toilet. When transferring the resident from toilet back to wheelchair, resident used grab bars to assist in standing up, HA C assisted resident with pulling up pants, in the middle of turning the resident's left knee buckled, HA C instructed the resident to try and stand up. Resident #24 reported she could not. HA C stated she heard a loud pop and assisted resident to the floor. Resident #56 called for assistance, the nurse and staff member reported to resident's room. HA C confirmed she was not a CNA (her certificate was expired since 2014), and stated she had to work with a certified nurse aide on the floor at all times. At the time of this interview HA C stated she had received an in-service on transfers of Resident #24 after the fall occurred on the evening of [DATE]. HA C stated she assisted Resident #24 to the toilet without assistance because the CNA was break. She stated she supposed to call the nurse because Resident #24 needed 2 persons for transfer. She stated she never transferred Resident #24 before, because as a HA she was not allowed to transfer Resident #24 or any other resident. In an interview with the DON on [DATE] at 3:30 PM, he stated hospitality aides were not allowed to provide any direct care to residents. He stated HA C should not transfer Resident #24. He stated if the CNA was not available the HA C should notify the nurse about Resident #24 needs. He stated hospitality aides were in-serviced on job description up on hire. The DON did not provide the in-service on job description for HA C to the surveyor. The DON stated Resident #24 was 2 persons assist with transfer. The DON stated the amount of assistance needed by a resident would be reflected in the Kardex system for nursing staff. The surveyor asked if the care plan populated the Kardex because the Kardex did not show before and after the incident that Resident #24 was a two-person assist for transfer. The DON stated he was, and the ADONs, responsible to oversee the care plans for updates and the Kardex to reflect the care plans. The DON stated charge nurses, ADONs himself did routine rounds to monitor to ensure transfers were being done appropriately. Record review of the facility's policy Transfers of Residents dated [DATE], reflected Transfers are defined as the act of moving a resident from one surface such as from the bed to the wheelchair or from the from the wheelchair to the toilet. The goal is to ensure the safety of the resident when moving from one place to another, to prevent injuries to the resident. Record review of the facility's policy titled Abuse, Neglect and Exploitation dated [DATE], reflected, .Neglect - means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Record review of the facility's policy titled Comprehensive Care Plans, dated [DATE] reflected, .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. (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 job description for a Hospitality Aide revised on [DATE] revealed: . Responsible for providing resident related (no-hands-on) care in accordance with quality standards under the direction of a licensed charge nurse. The position is applicable prior to successfully receiving certification as a nursing assistant. Performs host/hostess type duties in accordance with accepted standards of non-hands-on resident care. Uses daily task assignments. Assist residents that are independent and residents that require minimal or supervision support with activities of daily living, set up bed bath and rinse and soap wash cloth handing to patient. Lay out clothes, hold clothes in position patient can dress self, button clothes, pull up pants, changes unoccupied bed linens, answers call lights assist within skill level, passing and serving water. Assists with resident's recreation programs and transports residents in wheelchairs. Labels personal care items. Keeps resident rooms tidy. Maintains clothing inventory. Reports changes of resident condition to nurse in charge, reports accidents and incidents, and provides support functions as directed by supervisor. The facility administrator was notified on [DATE] at 12:30 PM that an Immediate Jeopardy situation had been identified due to the above failures. IJ template provided at this time and a Plan of Removal was requested. The facility's plan of removal was accepted on [DATE] at 6:05 PM and included: 1.On [DATE] resident # 24 was immediately sent the emergency room . 2.On [DATE] the hospitality aide involved in this incident was suspended until further notice 3.On [DATE] the DON/Designee completed the investigation on incident involving resident # 24. 4. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON on Job descriptions to include Hospitality Aides job duties, and Certified Aide job duties This was completed on [DATE]. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. 5. On [DATE] at 1:00 pm, the DON/Designee began in-service education with all clinical staff on Job descriptions to include Hospitality Aides job duties, and Certified Aide job duties to validate that each Aide had clear understanding of what was in their scope and practice. This was completed on [DATE] and no clinical staff will be allowed to work until this education has been completed. 6. On [DATE] the DON/Designee began in-service education with individual hospitality aides on their specific job duties and had the individual sign a new job description. This was completed on [DATE] either directly or by phone. This education included that at any time, a hospitality aide is performing care that is not in their job description, the DON/Administrator will be notified immediately, and staff will be asked to leave facility. This was completed on [DATE]. 7. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON/Designee on transfers which guides staff on how to properly and safely transfer residents according to their plan of care and type of device if needed. This was completed on [DATE] at 1:00 pm. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. On [DATE] at 2:00 pm the DON/Designee began in-service education with all clinical staff on transfers which guides staff on how to properly and safely transfer residents according to their plan of care and type of device if needed this included skills competency on Transfers (Hoyer and gait belts). This was completed on [DATE] and no staff will be allowed to work until this education has been completed. DON/Designee will complete weekly hoyer skills validations and gait belt skills validation on 5 C.N.A. weekly, rotation shifts x 90 days. The Regional Nurse consultant will provide oversight for this process and will review monthly. 9. On [DATE] at 12:30 pm, the Regional Nurse Consultant provided in-service education with the DON/Designee On use of PCC Kardex to determine type and amount care residents require, including reporting to Charge Nurse if ADLS are not present and or accurate on Kardex. This was completed at completed on [DATE]. The Regional Nurse Consultant will provide oversight on this process weekly x 4 weeks. 10. On [DATE] at 1:00 pm the DON/Designee began in-service education with all clinical staff on use of PCC Kardex to determine type and amount care residents require, including reporting to Charge Nurse if ADLS are not present and or accurate on Kardex. This was completed on [DATE], and no clinical staff will be allowed to work until this education has been completed. 11. On [DATE] the Regional Nurse Consultant provided 1:1 education to the Center's DON and two ADONS on care plans that they are responsible to review all incident reports including falls, updating care plan with appropriate interventions for each fall and make sure interventions are appropriate, ensuring timely completion and that interventions are reflective on Kardex. This was completed on [DATE]. 12. On [DATE] the facility conducted and Ad Hoc QAPI meeting to discuss Incidents/Accidents and Hazards and on sustaining compliance. On [DATE], the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by: Observation on [DATE] at 11:15 AM CNA G and CNA K transferred Resident #24 from bed to wheelchair, using the gait belt. Observation on [DATE] at 10:15 AM ADON A transferred Resident #9 from bed to wheelchair, using the gait belt. Record review of in-service reflected the Regional Nurse Consultant provided: - On [DATE] 1:1 education to the DON on the Incident/Accident Policy to include report and investigate all incident and accidents that occur in the facility in a timely manner, including appropriate interventions, updating care plans with appropriate interventions related to falls. - On [DATE] education with the DON on job descriptions to include Hospitality Aides job duties and Certified Aide job duties. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] education with the ADONs and the DON on care plans that they are responsible to review all incident reports including falls, updating care plan with appropriate interventions for each fall and make sure interventions are appropriate, ensuring timely completion and that interventions are reflective on Kardex. Record review of in-service reflected DON or designee provided: - On [DATE] education with all clinical staff on job descriptions to include Hospitality Aides job duties and Certified Aide job duties. - On [DATE] education with individual hospitality aides on their specific job duties and had the individual sign a new job description. - On [DATE] education with all clinical staff on transfers which guides staff on how to properly and safely transfer residents according to their plan of care and type of device if needed. - On [DATE] education with all clinical staff on use of PCC Kardex to determine type and amount care residents require, including reporting to charge nurse if ADLS are not present and or accurate on Kardex. Interviews conducted on [DATE] from 11:03 AM to 3:30 PM with 4 nurses (LVN M, LVN O, LVN Q, and LVN U), 6 hospitality aides (HA N, HA P, HA R, HA S, HA T, HA V), and 6 CNAs (CNA CC, CNA FF, CNA HH, CNA EE, CNA GG, and CNA KK) which represented all shifts revealed they had been in-serviced on abuse and neglect, they would check the Kardex system or ask their nurse to determine what level of care a resident required. Review of in-service records revealed they had been in serviced on the use of the Kardex/Plan of Care system and on transfers. Interviews with nursing management staff on [DATE] between 5:16 PM and 5:26 PM included ADON A and ADON B, revealed they had been in-serviced on neglect, resident transfer types and where to locate a resident's transfer status in the Kardex, which came from the care plan. Interview on [DATE] at 5:35 PM with the MDS Coordinator revealed she had been in-serviced on her job responsibilities as MDS Coordinator which included the different types of MDS's including comprehensive, annual, quarterly, and significant change. She stated that the MDS's trigger the care plan and Kardex. She stated that any acute changes are care planned and addressed in morning meeting with the interdisciplinary team, Monday through Friday. Interview on [DATE] at 5:00 PM with Regional Nurse Consultant revealed there were only 9 residents that needed an updated Kardex. Record review on [DATE] at 5:53 PM of 10 residents (Resident #3, #24, #6, #16, #33, #34, #36, #42, #54, and #58) Kardex's reflected their transfer status matched their MDS. Interview on [DATE] at 6:02 PM with the DON revealed he had been in-serviced on care plans and updating acute and comprehensive care plans including falls, fractures, and transfer assistance level. (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 [DATE] at 6:15 PM with the Administrator revealed during morning meetings they will care plan immediately any resident changes including falls, fractures, and transfers assistance changes. She stated the DON was responsible for acute and comprehensive care plans. She stated the MDS Coordinator was responsible for quarterly and change of condition care plans were completely. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 6:30 PM. The facility remained out of compliance at a severity level of actual harm and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on interview and record review the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents goals and preferences for two of two residents (Resident #123 and Resident #67) reviewed for dialysis. 1. The facility failed to ensure Residents #123 and #67's dialysis communication sheets were completed to coordinate care with the dialysis center. 2. The facility failed to ensure residents had physician orders for dialysis treatment and to inspect vascular access sites for Residents #123 and #67. These failures could place residents at risk of not receiving proper care and adequate coordination of care. Findings include: 1. Record review of Resident #123's, undated, face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #123 had diagnoses which included Congestive Heart Failure (long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), Hypertension, Seizures, Chronic Kidney Disease (disease your kidneys are damaged and can't filter blood the way they should) and Chronic Obstructive Pulmonary Disease (common lung disease causing restricted airflow and breathing problems). Record review of Resident #123's Admission MDS assessment, dated 08/13/24, reflected Resident #123 had a BIMS of 15, which indicated she was cognitively intact. Resident #123 was on hemodialysis while a resident at the facility. Record review of Resident #123's Comprehensive Care Plan, initiated on 08/12/24, reflected Dialysis: Resident received dialysis related to renal failure and was at risk for the potential complications of dialysis. Interventions included: Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure to the physician. AV (arteriovenous) shunt: Auscultate shunt site for bruit and palpate for thrill as ordered. Notify physician for absence of bruit/thrill. Monitor/document/report to physician any signs or symptoms of infection at the access site such as redness, swelling, warmth, pain, or purulent drainage. Record review of Resident #123's Current physician orders, dated 08/22/24, reflected no orders for dialysis treatment or dialysis access site. Record review of Resident #123's August 2024 MAR/TAR reflected no documentation for dialysis access site or dialysis treatment. Record review of Resident #123's nurse progress notes for August 2024 reflected the following about dialysis: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dated 08/09/24 at 6:45 PM by RN F reflected Resident returned from dialysis on no obvious distress, denies needs. Dressing to port . Call light in reach, monitoring. -dated 08/09/24 at 9:47 PM by RN F reflected .A dialysis catheter is present. The catheter is clamped. No changes are noted to the resident's bladder .or dialysis systems . Remains on skilled services, dialysis resident, able to make needs known. Becomes [short of breath] on exertion but denies this issue this shift, came back at [approximately] 1845 [6:45 PM] from dialysis in good spirits. dated 08/12/24 at 5:24 PM by RN F reflected Returned from dialysis in no obvious distress, calm and awaiting dinner. Vitals updated. Dressing .to [right] chest port. -dated 08/14/24 at 10:58 AM reflected Resident is skipping dialysis today due to a granddaughter's death and they will be having the viewing today and if she went to dialysis she would miss the whole thing. Warnings of the dangers of missing dialysis given to resident. Explained to patient that it was not a good idea for her to miss another session since she missed 1 last week while moving to Texas from Iowa. She says that she understands and this is just something that she has to do. Will continue to monitor. -dated 08/16/24 from RN F reflected Returned from dialysis in no obvious distress, just states she is tired and requested tylenol for fatigue and joint pain. Vitals have been updated. -dated 08/21/24 at 6:04 PM from RN F reflected Returned from dialysis in no obvious distress, vitals updated and port . Monitoring Observation and interview on 08/22/24 at 2:30 PM with Resident #123 revealed she had not received a dialysis communication before 08/21/24 and this was the first time it was provided to her so she could take it with her to dialysis. She stated when she was at another facility, she was given the dialysis communication sheets prior to dialysis, gave it to dialysis center and brought it back with her. She stated the nurse at the facility did her vitals prior to going to dialysis most of the time. Interview on 08/23/24 at 2:14 PM and 2:34 PM with the Treatment Nurse revealed when resident returned with the dialysis communication sheet from dialysis it was uploaded into the electronic record. She stated she could not find any dialysis communication sheets in Resident #123's electronic record. She stated she only worked as a floor nurse prn and she usually was the treatment nurse. She stated she completed a dialysis communication sheet for her today and did assess her which included vitals prior to Resident #123's transportation arrival to take her to dialysis. She stated she could not find the dialysis treatment order for Resident #123 and the order to assess the dialysis access site for Resident #123. She stated she did the assessment which included vitals this morning and used the weight which was in the system for the pre-treatment weight. She stated she could not recall any training about dialysis communication sheets and stated she filled it out best she could. She stated Resident #67 was provided the dialysis communication sheet today and was still gone to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/23/24 at 3:22 PM with RN F revealed she worked during the week on the evening shift and Resident #123 went to dialysis on Mondays, Wednesdays and Fridays. RN F stated Resident #123 returned on her shift usually in the evening. She stated she only received the dialysis communication sheet for 08/21/24 from Resident #123 until yesterday (08/22/24). She stated 08/21/24 was the first time she received a dialysis communication sheet for Resident #123. RN F stated she put vitals and assessed Resident #123's dialysis access site when she returned. She stated Resident #123 had been on dialysis since she admitted . She would write a progress note and input vitals into the electronic system on dialysis days when she returned. She stated the admitting nurse was responsible to ensure dialysis orders were in the electronic record. She stated there were no orders for monitoring Resident #123's dialysis access site. 2. Record review of Resident #67's, undated, face sheet reflected Resident #67 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #67 had diagnoses which included End Stage Renal Disease (Kidney Failure), Fluid Overload, Idiopathic Peripheral Autonomic Neuropathy (nerve damage outside your brain or spinal cord) and Hypertension secondary to Renal Disorders (high blood pressure caused by the narrowing of your arteries that carry blood to your kidneys). Record review of Resident #67's quarterly MDS assessment, dated 06/19/24, reflected Resident #67 had End Stage Renal Disease since admission. Resident #67 had a BIMS of 15, which indicated he was cognitively intact. Record review of Resident #67's Comprehensive Care Plan, initiated on 03/17/24, reflected Dialysis: Resident was at risk for the potential complications of dialysis related to renal failure. Interventions included: Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure to the physician. AV (arteriovenous) shunt: Auscultate shunt site for bruit and palpate for thrill as ordered. Notify physician for absence of bruit/thrill. Monitor/document/report to physician any signs or symptoms of infection at the access site such as redness, swelling, warmth, pain, or purulent drainage. Record review of Resident #67's Current Physician Orders, dated 08/23/24, reflected the following: - Order dated 04/13/24 dialysis to be performed [Dialysis Company] on Mon, Wed, and Fri It did not give any more information about dialysis treatment. There was no physician order for monitoring dialysis access site for Resident #67. Record review of Resident #67's Progress notes, about dialysis treatment for 07/22/24 to 08/23/24, reflected the following: -dated 07/22/24 at 5:50 PM by LVN E reflected Resident returned from dialysis in [wheelchair] via facility transportation. Resident was in pleasant mood and no s/s of distress noted. Resident fistula to left forearm clean, dry and intact. Resident's dialysis catheter clean, dry and intact. V/S 97.5-142/114-102-18. Will continue to monitor dated 07/29/24 at 5:58 PM by LVN E reflected Returned from dialysis in w/c via facility van. Resident in pleasant mood no complaints of pain or cramping. Fistula to left forearm dressing [clean/dry/intact]. V/S 97. 2-88-97/58 will continue to monitor. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-dated 07/31/24 at 11:31 PM by LVN E reflected Resident returned from dialysis at 1720 [5:20 PM] in wheelchair via facility van. Resident was in pleasant mood. Resident complained of pain to fistula site, which was dressed and [clean dry intact]. This nurse gave PRN Hydrocodone @1725. V/S 98.3-130/91-81 -dated 08/09/24 at 5:14 PM by LVN E reflected Resident returned from dialysis in w/c via facility van. Resident in pleasant mood and complaining of pain rated 5/10. Received PRN Hydrocodone at this time. V/S 98.4-82-131/77-18. Dressing to left forearm [clean/dry/intact] Resident states that his dry weight is 272.0 -dated 08/15/24 at 4:23 PM by RN J reflected Resident's shorts noted having blood saturation on the left leg when he returned from dialysis. The nurse asked him what had happened and he stated his shunt had leaked. RN assessed and found the shunt was no longer leaking. RN assisted the resident in changing his shorts and discovered his wallet had been saturated as well. Resident cleaned up and dressed with clean shorts. Soiled shorts and contaminated wallet along with contents were given to housekeeping manager who cleaned and sanitized the items. Wallet returned to resident. -dated 08/19/24 at 5:46 PM by LVN E reflected Resident returned from dialysis in w/c via Facility van. V/S 157/99-100-98.2 Resident in pleasant mood, c/o pain and requested pain medication and PRN norco given as ordered. Fistula dressing [clean/dry/intact]. Record review of Resident #67's July and August 2024 MAR/TAR reflected no documentation for dialysis access site or dialysis treatment. Record review of Resident #67's Dialysis Communication Record for July to August 2024 reflecting the following: -dated 08/12/24 reflected no documentation from facility nurse prior to after dialysis treatment. It reflected pre and post treatment completed by dialysis facility. There were no other dialysis communication sheets for July to August 2024. Interview on 08/23/24 at 3:38 PM with RN J revealed Resident #67 was on dialysis since admission. RN J stated she thought the dialysis communication forms originated from the dialysis center and did not know the facility nurse was supposed to initiate and complete the dialysis communication form. She stated she was not aware she was supposed to complete the dialysis communication sheet pre and post dialysis for Resident #67. She stated she had not received any in-service on dialysis communication forms. She stated she was aware needed to assess Resident #67's dialysis access site pre and post dialysis but there were no physician orders for Resident #67's dialysis treatment or to assess his access site. She stated she had no where specifically to document her assessing the access site on dialysis days or to put the vitals so she would write a progress note and put it in the vitals. Interview on 08/23/24 at 3:40 PM with LVN E revealed she was not receiving dialysis communication sheets on Resident #67 and was not in-serviced on dialysis communication sheets. She stated when Resident #67 returned from dialysis she would assess him post dialysis which included his vitals and dialysis access site in the electronic record. She stated she only received communication from the dialysis center once for a resident. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/24/24 at 4:14 PM with the ADONs A and B revealed all dialysis residents should have a physician order for dialysis. She stated the admitting nurse was responsible to ensure physician orders for dialysis were inputted upon admission for residents. The ADONs stated they or the DON were to review the admitting physician orders and compare to the hospital orders. The ADONs stated the nurse should input vital signs in the communication sheets before dialysis and the dialysis center should input vital signs and weight after dialysis and send it back with the resident. The ADON stated the purpose of the dialysis communication sheets were to monitor the resident before and after dialysis to determine how effective the dialysis was. Both ADONs stated they or the DON were supposed to monitor that the dialysis communication sheet was completed by the nurses, the dialysis center completed and received it back from the dialysis center. Interview on 08/24/24 at 04:26 PM with the DON revealed the admission nurse should be putting in dialysis orders upon admission. The DON stated he should review the chart within 72 hours after admission to ensure orders were in the resident charts. He stated he expected the charge nurse to complete the dialysis communication sheet which included vitals and the dialysis access site. The DON stated the dialysis communication sheet should have vitals and weights on it. He stated the dialysis communication should return with the resident and after the dialysis nurse should check vitals, the access site and review the dialysis treatment. He stated it was important to complete the dialysis communication sheet to determine how effective dialysis was for the resident. He stated the ADONs and the DON should be checking to ensure dialysis communication sheets were completed once a week. He stated there was not an in-service done on dialysis communication sheets since he had been the DON. Record review of the facility's policy Management of Resident Receiving Hemodialysis dated 06/01/24 reflected The interdisciplinary team will be in direct communication with the dialysis team to ensure that the coordination of care continues over the health care continuum .1. Residents receiving hemodialysis will have an order obtained from Physician and must include the following -Name and phone number of the Dialysis center - Address of the Dialysis Center - Days of the week that dialysis is performed - Usual time for pick-up by transport - Name and phone number of the transport company if applicable .5. Residents that are able to independently be transferred to and from dialysis will be provided with education on the following: -The importance of leaving with their dialysis communication form and giving it to the dialysis nurse. -The importance of giving the Dialysis communication .to the Charge Nurse upon return .7. Residents receiving hemodialysis will have an order to inspect their vascular access(s) each shift .11. The nurse on the unit is responsible for completion of the Dialysis communication form and check the vascular access prior to leaving for dialysis .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42971 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 3 medication carts (Nurses cart hall 3) reviewed for pharmacy services. The facility failed to ensure RN J, responsible for Nurses Cart hall 3, removed medications in unsecure containers from the Nurses Cart. This failure could place residents at risk of not having the medication available due to possible drug diversion and at risk of not receiving the intended therapeutic benefit of the medication. Findings include: Record review and observation on 08/20/24 at 11:38 AM of Nurses Cart Hall 3, with RN J revealed the blister pack for Resident #69's Acetamin-codeine 300-30 mg tablet (controlled medication used for pain) had 2 blister seals broken and the pills still inside the broken blisters. Interview on 08/20/24 at 11:54 AM, RN J stated she was unaware when the blister pack seals were broken, and she was not aware of who might have damaged the blisters. She stated the risk would be a potential for drug diversion. She stated the nurses were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated the count was done at shift change and the count was correct. She stated she did not see the broken blister during the count because she did not check the back of the blister pack. She stated when a broken seal was observed, she would report it to the DON and would discard the pill with another nurse . She stated the risk would be potential for drug diversion. Interview on 08/24/24 at 4:26 PM, the DON stated he expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened . The DON stated the risk would be potential for drug diversion and infection control issue. He stated nurses were responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADONs, and the DON were supposed to check the carts weekly. Record review of the facility's policy Storage of Medications revised August 2020, reflected the following: . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34399 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for three of four dietary staff (Dietary Aide Y, Dietary Aide Z and Dietary Manager) and the facility's only kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure the low temperature dish machine was working properly on 08/20/24 to ensure appropriate chlorine sanitizer ppm levels. 2. The facility failed to ensure the Dietary Aide Y, Dietary Aide Z and the Dietary Manager wore an effective hair restraint during the lunch meal preparation on 08/20/24. 3. The facility failed to ensure Dietary Aide Y and Dietary Aide Z performed hand hygiene during the lunch meal preparation on 08/20/24 These failures could place residents at risk for food contamination and food-borne illness. Findings include: 1. Observation on 08/20/24 at 10:10 AM revealed the low temperature dish machine was 127 degrees Fahrenheit for wash and 135 degrees Fahrenheit for rinse. The Dietary Manager used chlorine test strips and the strip did not change color to test the ppm. The Dietary Manager ran the low temperature dish machine again two more times and unable to get the strip to change any color. Interview on 08/20/24 at 10:18 AM with the Dietary Manager revealed the chlorine test strips should be changing color to indicate the chlorine sanitizer level for the low temperature dish machine. She stated this morning it was working. She stated it should read 50 ppm to 100 ppm. She stated she would have to contact the Contract company to get a representative out to look at it. She stated she would have to stop using the low temperature dish machine until it could be looked at to ensure proper sanitization levels to clean and sanitize dishes. Observation on 08/20/24 at 10:22 AM of Low Temperature Dish Machine Temperature and Sanitizer Log on the wall of the dish room revealed no sanitizer or temperature documented for the low temperature dish machine for 08/20/24. The last documented was on 08/19/24 at 2:00 PM which reflected water temperature was 123 degrees Fahrenheit and concentration (sanitizer level) was 100 ppm. Interview on 08/20/24 at 10:23 AM with Dietary Aide BB revealed he had not checked the sanitizer and temperature for the dish machine this morning so it was not documented on the log today. Follow-up Interview on 08/20/24 at 12:27 PM, the Dietary Manager stated a representative from the contract company came out and looked at the dish machine. She stated the low temperature dish machine was not showing sanitizer due to the line being clogged but it now had been fixed by the contract company representative. She stated it now reads the proper ppm for sanitizer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Observation on 08/20/24 at 11:51 AM revealed the Dietary Manager wore a hair restraint that did not cover about 2 inches below the hair restraint in the back and about 1 inch near both of her ears while she was getting food out of oven. Observation on 08/20/24 at 11:53 AM to 12:05 PM revealed Dietary Aide Z wore a hair restraint that did not cover 3/4 inch above both of her ears and 2 inches of hair in the back while she did the food temperatures for lunch prior to serving. Observations on 08/20/24 from 12:10 PM to 12:43 PM during the lunch meal revealed Dietary Aide Z was getting a clean plate, scooped food and placed food on resident lunch plates with hair restraint not effectively covering 3/4 inch above both of her ears and 2 inches of hair in the back her hair. At 12:35 PM, Dietary Aide Z touched her face with her left hand, did not wash her hands and continued plating the food. Dietary Aide Y had a hair restraint not covering about 1/2 inch of hair above both of her ears and about 1.5 inches in the back of her hair. Dietary Aide Y was scooping food and putting biscuits on resident lunch plates. At 12:39 PM, Dietary Aide Y touched her face with her gloved hand. She did not take the gloves off and wash her hands. Dietary Aide Y continued plating food and putting biscuits on resident lunch plates with her gloved hands. Observation on 08/20/24 at 12:30 PM revealed the Dietary Manager with a hair restraint not covering about 2 inches below the hair restraint in the back and about 1 inch near both of her ears while she was in the dish area running the low temperature dish machine. Interview on 08/20/24 at 12:45 PM with Dietary Aides Y and Z revealed they were not aware their hair restraints were not covering their hair above the ears and in the back. Dietary Aide Y and Z stated they should wash their hands if they touched their face. Interview on 08/20/24 at 12:47 PM with the Dietary Manager revealed she did realize her hair restraint was not covering her hair completely. She stated she should have ensured her hair restraint was covering her hair in the kitchen. Follow-up interview on 08/20/24 at 2:10 PM with the Dietary Manager revealed all dietary staff which included herself should ensure hair was effectively covered to prevent hair from getting in the food and cross contamination. She stated dietary staff should be washing their hands when touching their face and put new gloves on to prevent cross contamination. She stated it was important to ensure the dish machine was sanitizing the dishes properly. Review of facility's in-service dated 07/24/24 included hand hygiene reflected ADON B in serviced Dietary Aide Y, Dietary Aide Z and Dietary Manager. Interview on 08/25/24 at 6:33 PM with the Administrator revealed it was important for dietary staff to have effective hair restraints to keep hair out of food and keep food from contamination. She stated hand hygiene was important to ensure dietary staff did not place residents at risk for illness and cross-contamination. She stated the dish machine meeting the minimum sanitization level ensured dishes were clean and sanitized properly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility's policy Ware Washing dated 08/2005 and last reviewed on 05/2015 reflected under procedure for Machine ware washing, 3 .Dish Machine temperatures (wash and rinse) will be observed and recorded on the Dish Machine Temperature Log before starting the ware washing process after each meal. For low temperature machines the chemical sanitizer strength will be tested and recorded as well. 4. Improper temperatures and/or sanitizer strength will be reported to the person in charge immediately and manual ware washing and/or paper products will be implemented until the problem is corrected Low temperature Dish machines b. chemical: Chlorine sanitizer 50 ppm . Record review of the facility's policy Personal Hygiene dated 11/2006 and last revised 11/2017 reflected Dietary employees will maintain proper Food safety practices through proper personal hygiene. Proper hand washing techniques and exclusion of infectious individuals from handling food are critical for prevention of foodborne illness .The health and personal hygiene habits of food service workers when not handled properly may potentially cause food contamination .4 .Hands must be washed between each glove use .11. Dietary employees shall wear hair covering, beard restraint, and clothing that covers body hair. Any staff entering the kitchen must comply with hair restraints and hand washing . Record review of the facility's policy Food Safety and Sanitation Plan dated 09/2005 and last reviewed on 07/22/21, reflected .ensures safe food handling practices from food procurement through food service. While all steps in the handling of food are important, specific steps have been identified as 'critical' in preventing food borne illness .Nursing home resident risk serious complications from foodborne illness as a result of their compromised health status. Unsafe food handling practices present a potential source of pathogen exposure for residents. Sanitary conditions must be present in health care food service settings to promote safe food handling .13. Personal Hygiene Practices - Thorough hand washing is required (but not limited to) the following situations .D. after .touching hair or face Record review of the FDA US Food Code 2022 reflected the following: -under section 2-3 Personal Cleanliness 2-301.11 Clean Condition Food Employees shall keep their hands and exposed portions of their arms clean. -under section 2-402.11 Effectiveness. (Hair Restraints) 1. Code of Federal Regulations, Title 21, Sections 110.10 Personnel. (b) (6) Wearing, where appropriate, in an effective manner, hair nets, head bands, caps, beard covers, or other effective hair restraints.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on observation, interview and record review the facility failed to maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 8 residents (Resident #18, Resident #4, Resident #36, and Resident#69) reviewed for infection control. 1. The facility failed to ensure RN I disinfected the blood pressure cuff in between blood pressure checks for Residents #18, #4 and #36. 2. The facility failed to ensure CNA G changed soiled bed linen after she performed incontinence care for Resident # 69. These failures could place residents at-risk of cross contamination which could result in infections or illness. Findings include: 1. Record review of Resident #18's Comprehensive MDS assessment, dated 07/16/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #18 had diagnoses which included elevated blood pressure, dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), and cerebral infarction (damage to the brain from interruption of its blood supply). Resident #18 had a BIMS of 15, which indicated Resident #18's cognition was intact. Record review of Resident #4's Quarterly MDS assessment, dated 07/18/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment) and elevated blood pressure. Resident #4 had a BIMS of 08, which indicated Resident #4's cognition was moderately impaired. Record review of Resident #36's Quarterly MDS assessment, dated 07/30/24, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #36 had diagnoses which included elevated blood pressure, type 2 diabetes mellitus and chronic kidney disease. Resident #36 had a BIMS of 14, which indicated Resident #36's cognition was intact. Observation on 08/21/24 at 7:40 AM revealed RN I performed morning medication pass, during which time she checked the blood pressure on Resident #18. RN I did not sanitize the blood pressure cuff before and after use on Resident #18 and continued to the next resident without sanitizing the blood pressure cuff. RN I then checked Resident #4's blood pressure. RN I did not sanitize the blood pressure cuff before using it on Resident #4. RN I continued to the next resident without sanitizing the blood pressure cuff. RN I then checked Resident #36's blood pressure. RN I did not sanitize the blood pressure cuff before using it on Resident #36 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 08/21/24 at 8:20 AM, RN I stated reusable blood pressure cuffs, should be sanitized before and after use on each resident. She stated the risk of not sanitizing the blood pressure cuff between use would be cross contamination and spread of infections. She stated she forgot to sanitize the blood pressure cuff between use on Residents #18, #4, and #36. Record review of the facility's policy titled, Care, Cleaning and Storage of Equipment reviewed 2/13/2020, reflected, . Resident equipment is to be cleaned with EPA approved disinfectant or similar agent between residents 2. Record review of Resident #69's Comprehensive MDS assessment, dated 08/01/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS of 11, which indicted Resident #69's cognition was moderately impaired. Resident #69 had diagnoses which included type 2 diabetes mellitus, pancreatic cancer, and muscle weakness. Resident #69 was dependent requiring 2 persons assist with toileting hygiene and transfers. Record review of Resident #69's care plan with an onset date of 07/30/24 reflected, Focus: Incontinence: [Resident #69] is incontinent of bowel/bladder related to muscle weakness. Goal: The resident will be clean and odor free . Interventions: Incontinent: Check frequently for wetness and soiling and change as needed. Observation on 08/20/24 at 10:40 AM revealed CNA G and CNA H entered Resident #69's room to provide incontinence care. Both staff washed their hands and donned gloves and gowns CNA G unfastened the brief and cleaned the front pubic area using incontinent wipes. The resident was assisted onto her side. CNA H held resident on the side and CNA G cleaned the resident's buttocks area using several wipes revealing a medium bowel movement. Some of the bowel movement fell on to the bed linen. CNA G removed the bowel movement from the bed linen using wipes. CNA G discarded the dirty gloves, sanitized hands and she donned clean gloves, she placed a clean brief under the resident. Both staff repositioned the resident back on her back, onto the dirty linen. Both CNAs removed their gloves and gowns, and washed their hands and left the room. In an interview on 08/20/24 at 10:56 AM, CNA G stated she was supposed to change the bed linen after it was soiled by the bowel movement. She stated it was not acceptable to lay down a resident on dirty linen. She stated she did not change the bed linen because she was focused on hand hygiene, and she forgot to change the linen. CNA G stated the risk would be spread of infection and contamination of the resident environment. In an interview with the DON on 08/24/24 at 4:26 PM, he stated all the staff were trained numerous times on the expectation of sanitizing blood pressure cuffs after each use. The DON stated the CNA was to change the bed linen after it was soiled with the bowel movement to prevent the spread of infection. The DON stated to ensure staff were knowledgeable in the infection control practices he and the ADONs made daily rounds and watched care. Record review of the facility's policy titled, Hospitality Services reviewed May 2003, reflected . Infection control is paramount in this area. and the prevention of spreading infection must always be taken into consideration. Cross-contamination should be a concern in any areas containing clean or soiled linen.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 49640 Based on observation, interview and record review the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents in the facility's only kitchen, only dining room area, and two of two resident rooms reviewed for pest control. 1. The facility failed to ensure the kitchen was free of flies. 2. The facility failed to ensure resident rooms were free of flies. 3. The facility failed to ensure installed pest control measures in resident rooms and the dining area were operational and clean. These failures could place residents at risk for cross contamination, food borne illnesses, and the spread of infection and disease, and a reduced quality of life. Findings include: Observation on 08/20/24 at 10:05 AM revealed 6 flies in kitchen landed on the trash can lid and 2 of the flies landed on the counter of food preperation area. Observation on 08/20/24 at 11:45 AM revealed 7 flies in the kitchen which landed on the trash can side and lid. Observations on 08/20/24 at 12:11 PM and 12:24 PM revealed a fly flew over the steam table while food was not covered . Observation on 08/20/24 at 12:15 PM revealed one small flying insect on the 3rd rack where bread was stored. Observation on 08/20/24 at 12:42 PM revealed 1 fly landed on a Splenda packet and another fly landed on a sour cream packet. Interview on 08/20/24 at 2:10 PM with the Dietary Manager revealed they cleaned the kitchen trash can and lid. She stated the pest control treated the drains for drain flies. She stated the facility had flies for about the last couple of months. She was not aware of a small flying insect on the bread rack and would have to look at the bread to look to see if any other flies were on them. An interview and observation of Resident #57 on 08/20/2024 at 2:50 PM revealed her to be in her room. A fly was observed to land near the resident's mouth. The resident stated she had a fly swatter and so did her roommate. Two flies were observed on the inside window in the resident's room. Observation of Resident #47 on 08/20/2024 at 12:30 PM, in the dining room, reflected the resident holding a fly swatter. Resident #47 was observed swatting flies on the table multiple times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455961	A. Building B. Wing	08/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palo Pinto Nursing Center	200 Southwest 25th Ave Mineral Wells, TX 76067

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a confidential group interview revealed the smoking area brought a lot of flies into the building. The smoking area was near the dining room. The flies were annoying and nasty especially when there were activities in the dining room like bingo Everyone was swatting flies or each other during activities in the dining room. An interview with the EVS Manager (Environment Services) on 08/20/24 at 03:30 PM, revealed he was unaware of the fly issue. The EVS Manager stated there was a bug/fly trap near every exit door near the dining room and at the end of halls 1, 2, 3 and 4. The EVS Manager stated pest control went out weekly to change them out. The EVS Manager stated no one complained to him about the flies inside the building nor in the kitchen. The EVS Manager stated maintenance would receive complaints regarding flies. An interview with the Maintenance Director on 08/20/24 at 3:48 PM revealed an Aerator was installed that pushed air out so flies couldn't fly in. The Maintenance Director stated there was an Aerator near the smoking exit, a high traffic area. The Maintenance Director stated 8 lights were installed which contained UV lights with a sticky trap inside of them. He stated there was a light located inside of the door for hall 2, 3 in the dietary area (near the smoking door, near the kitchen, outside of the dishwasher), top of hall 1, the bottom of hall 4, outside of therapy (hall 3), and the top and bottom of hall 1. He said the Aerator was approximately 6 feet high. He stated he checked to ensure doors throughout the facility were sealed top and bottom and checked windows. He stated Pest Control went out weekly. He stated he received complaints regarding the flies. He stated he was limited due to the types of chemicals that could be used. He stated he was asked to refrain from using sticky traps and could only use sticky tubes outside of the building, not inside. He said he couldn't use heavy, evasive chemicals. He stated warmth attracted the flies in the kitchen area. He stated new air conditioning (A/C) units were being installed. He stated there was a new A/C unit in the kitchen. Observation on 08/22/24 at 10:45 AM revealed the location of the UV lights with sticky traps on hall 1 (3 UV lights observed), hall 2 (2 UV lights observed), hall 3 (2 UV lights observed) and hall 4 (2 UV lights observed). One UV light was observed in the dining room and kitchen. An interview with the Service Supervisor at with the Pest Control company on 08/23/2024 at 11:43 AM revealed there were 14 fly lights placed throughout the facility which contained UV lights to attract flies. He stated the fly/bait treatment administered at the facility during weekly visits took time for effect. He stated the fly issue at the facility had been on/off. He stated the facility was in a dry area which attracted flies plus the hot temperature outside. He said the door of the facility near the courtyard had lots of traffic in/out which caused flies to enter. Record review of the facility's Pest Control reports from June 2024 to August 2024 reflected fly issues brought to the Tech's attention and fly treatment were addressed in every report within this time frame. Record review of the facility's Dietary Policy and Procedure Manual revised 03/2012 reflected: Policy: The Dietary Department will maintain effective pest control program. Fundamental Information: An integrated pest management program consists of 5 steps: Inspection, Identification, Sanitation, Application of two or more pest management procedures, Evaluation of effectiveness of pest control measures, thorough follow-up inspections.