STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	45F410	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Francis Nursing Home	630 W Woodlawn Ave San Antonio, TX 78212

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review the facility failed to ensure based on the comprehensive assessment of a resident, that resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 4 residents (Resident #1) reviewed for quality of care. 1. The facility failed to ensure appropriate and timely care when Resident #1 had a fall on 4/16/2025 and was diagnosis with a fractured C1 vertebrae, traumatic subarachnoid hemorrhage, scalp laceration requiring repair and hematoma/contusion. 2. The facility failed to ensure LVN B did not move Resident #1 with a mechanical lift after a fall on 04/16/2025. 3. The facility failed to ensure LVN B immediately notified 911 after Resident #1 sustained a head injury with a laceration and excess bleeding, a large hematoma to the forehead, facial bruising, altered vital signs and was uncooperative. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/23/25. The noncompliance began on 4/16/2025 and ended on 4/22/2025. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or additional injury, paralysis or death. The findings included: Record review of Resident #1's face sheet, dated 4/22/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: history of falling, altered mental status and unsteadiness on feet. Record review of Resident #1's initial History and Physical report, dated 11/14/2024, revealed the resident was alert and oriented x 2, legally blind, wheelchair dependent and needed assistance with all ADL's. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan, last revised 11/21/2024, revealed she required assistance with mobility, positioning, transfers in bed, wheelchair, and walker, personal hygiene which included bathing, dressing, grooming and hygiene. The Care Plan indicated Resident #1 utilized a bed hand rail x 1 to assist with transfers. Record review of Resident #1's Care Plan last revised 11/21/2024, revealed she was at risk for falls and injury related to impaired physical mobility, impaired vision, and history of falling with interventions which included anticipate and assist with ADLs, assist with transfers, call light in reach and ensure proper footwear. Record review of Resident #1's quarterly MDS assessment, dated 2/17/2025, revealed a BIMS of 99 which indicated a severe cognitive impairment with both long- and short-term memory problems and was severely impaired. The assessment indicated Resident #1 was dependent on staff for all ADL care and substantial assistance for movement. Record review of Resident #1's Fall Risk Assessment, dated 3/09/2025, revealed she was at High Risk for falls due to the following contributing factors: intermittent confusion, history of 1-2 falls in past 3 months, chair bound with a note the resident could rise from chair with use of arms, legally blind, taking 3-4 medications considered at risk for falls, and had 1-2 predisposing diseases that increased the risk of falls. Record review of Resident #1's nurse progress notes, dated 4/16/2025 at 6:30 p.m., documented a CNA (CNA A) informed LVN B the resident was on the floor. LVN B noted Resident #1 lying next to her bed with the wheelchair at the foot of the bed. The resident had a laceration on the scalp with a large amount of bleeding. Towels were applied on the scalp to stop the bleeding. LVN B further documented the resident was turned and a sling was positioned under her. Resident #1 was then transferred to bed with a mechanical lift. LVN B documented Resident #1 refused ice on the laceration to the scalp and the mass above her right eyebrow that was greater than 5 cm. LVN B documented vital signs of 182/120 (normal 120/80 or lower) HR 91 (normal 60-100), respirations 22 (normal 16-29), temperature 97.3, oxygen saturation 92% (normal 90-100) on room air. LVN B documented Resident #1 refused neuro checks to be done and she responded to verbal stimuli with clear speech to answer yes/no questions. Record review of Resident #1's nurse progress notes, dated 4/16/2025 at 7:00 p.m., written by LVN B revealed Resident #1's physician was informed of the resident's condition with orders to send to the hospital for head trauma. Record review of Resident #1's nurse progress notes dated 4/16/2025 at 7:30 p.m., written by LVN B, revealed Resident #1 continued to refuse ice packs on mass, indicating the towels on laceration, the bleeding had decreased some. Vital signs 168/107, pulse 88, respirations 18, oxygen saturation 94% on room air. Record review of Resident #1's nurse progress notes, dated 4/16/2025 at 7:38 p.m., LVN B documented the DON aware of resident's condition. EMS services on their way. Record review of Resident #1's progress notes, dated 4/16/2025 at 7:45 p.m., LVN B documented EMS arrived. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of Resident #1's hospital record dated 4/16/2025 revealed she was treated a laceration to scalp requiring 6 sutures (stitches) and 5 staples to close, multiple traumatic subarachnoid hemorrhages, and a C1 [NAME] fracture as a result of an unattended fall at the NF. During her hospital she had a CT head scan which revealed: 1. Focal subarachnoid hemorrhage (bleeding in the space that surrounds the brain and is considered a medical emergency) 2. Acute C-1 cervical vertebral fracture/Jefferson fracture (fracture of the first spinal vertebrae) 2. Contusion/hematoma of right front scalp (bruising and swelling). During her hospital stay a follow up CT scan showed slight enlargement of the bleed (subarachnoid) with multiple new small subarachnoid bleeds, new edema (swelling) to the C1 fracture area, edema noted to other parts of the spine concerning for subtle compression fractures requiring ICU (intensive care) observation and care. Resident #1 was started on the medication Keppra (anti-convulsant medication) as a seizure prophylaxis (to prevent the occurrence of seizure activity). Record review of LVN B's Consultation Form, dated 4/18/2025, revealed LVN B received a consultation for a fall with head injury. The DON documented LVN B did not use proper nursing judgement to Resident #1 who had a head injury and fractured neck. The DON wrote LVN B should have immediately called EMS and left the resident without repositioning to the bed. During an observation and interview on 4/22/2025 at 11:30 a.m., Resident #1 was observed at a local hospital. She was in bed with a hard c-collar in place. Her eyes were puffy and swollen and she was unable to fully open them. She had a bandage in place at the top of her scalp where the forehead met the hairline. She had severe bruising to her forehead with noted swelling to the forehead. She had a bilateral peri -orbital bruising. All bruising was noted to be black and varying shades of purple with some dark shades of yellow/green near the edges. Resident #1 attempted to open her eyes when spoken to. She acknowledged she was being spoken to but was unable to answer any interview questions. She responded by making noises and grunting only. During an observation and interview on 4/23/2025 at 10:35 a.m., Resident #1 was observed in bed at the nursing facility. The head of her bed was elevated to 75 degrees. She had on a hard c-collar. Her face was bruised in varying shades of black, purple, green, and yellow with the largest portion of bruises noted to her forehead and eyes and mid-face. She had a bandage to her upper forehead and swelling to the upper forehead. Resident #1's bed was in the low position with a staff member at the bedside. Resident #1 only responded with grunts and sounds when spoken to. During an interview on 4/22/2025 at 7:05 p.m., Resident #1's RP stated he was notified on 4/16/2025 at 7:15 p.m. by an unknown nurse that his family member had fallen from her wheelchair, hit her head and was on the way to the hospital. He stated he had concerns about the seriousness of Resident #1's injuries which he stated he had discussed with the NF head staff. He stated Resident #1 would return to the facility today (4/22/2025). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/23/2025 at 12:50 p.m., LVN B stated on 4/16/2025 at 6:30 p.m., CNA A came shouting in the hallway Resident #1 was on the floor. LVN B stated she responded and found Resident #1 lying face down on the floor with an open wound to her forehead. LVN B stated Resident #1 had a lot of bleeding. She stated the wheelchair was at the foot of the bed and Resident #1 was next to the bed. LVN B stated her main concern was getting Resident #1 stabilized by putting pressure on her forehead. She stated she utilized a mechanical lift to pick Resident #1 off the floor and transfer her to the bed before calling the MD or 911. LVN B stated there was blood all over the floor and she (LVN B) did not want to fall because of it. She stated she was focused on applying pressure and stopping the bleeding. LVN B stated she did not call the MD until approximately 7:00 p.m. (which was approximately 30 minutes after the fall), then she called the DON around 7:30 p.m. (approximately 1 hour after the fall) who told her to call 911 . LVN B stated she called EMS around 7:35 p.m. LVN B stated at that time Resident #1's blood pressure was very elevated at 200/180, with an increased pulse over 100, increased respiratory rate of 24-26. LVN B stated EMS services arrived at approximately 7:40 p.m. and transferred the resident to the hospital. LVN B stated she was trained to keep a resident with a head injury spine in alignment by log rolling her and moving her carefully. She stated Resident #1's spine was not kept in alignment when she utilized a sling to transfer the resident with the mechanical lift because her priority was to stop the bleeding. LVN B stated she knew it was important not to move a resident with a head injury so it would not damage them anymore. LVN B stated Resident #1 had a big mass, a big hematoma to her forehead and was not cooperative with the assessment or with the care. She stated she was trying to put an ice pack on her forehead but Resident #1 would not cooperate. LVN B stated she waited over an hour to call 911 because she was trying to stabilize the bleeding. LVN B stated at the time, she thought she was doing everything she could for Resident #1 but admitted she did not ask for assistance. She stated in hindsight, she should have called another nurse to help her, and she should have called the DON as soon as possible. LVN B stated after the incident, the facility tried to figure out what happened. She stated she received a nurse consultation from the DON. She stated in the consultation she told the DON her main concern was to stop the bleeding. LVN B stated she learned in the consultation she should have called 911 as soon as possible with a head injury, especially with one from a fall of this magnitude. LVN B stated in addition to the discipline, she received additional training on not moving the resident at all and calling 911 immediately. LVN B stated she was also trained on log rolling residents in a c-collar, repositioning residents was completed before she was allowed to work again (unknown date). She stated she was also re-trained to ask for help, especially from another nurse who was also working and she knew what she did wrong. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/23/2025 at 1:46 p.m., the DON stated Resident #1 was blind, was able to mainly respond to yes/no questions, but not use too many words and was confused. She stated on 4/16/2025, Resident #1 had a very bad accident while CNA A was taking care of her from a fall. The DON stated she was not in the facility when the fall occurred. She stated she found out about it when she received a text from LVN B. The DON stated she came to the facility and Resident #1 was still there and 911 had already been called. The DON stated Resident #1 looked terrible. She had a bump on her head, and she had blood all over. The DON stated there was a delay in calling 911 for assistance. She stated the incident had occurred at 6 something and EMS came over an hour later. The DON stated she did not know why it happened. She stated she thought LVN B panicked because she kept talking about the blood. The DON stated LVN B should have called 911 immediately and she should not have moved Resident #1 from the position she was found in. The DON stated LVN B stated she felt very bad about transferring the resident after the accident. The DON stated staff were trained prior, that if there was an injury to the resident, they call 911 and do not move them. The DON stated now the NF knew of Resident #1's injuries, she could have been paralyzed. The DON stated she monitored staff by being present and ensuring the residents were not neglected. She stated she was at the facility all the time and worked late. She stated she was also available any time and she ensured the staff had the training and competencies. The DON stated post incident, the LVN received additional counseling and training and the Administrator, who conducted the investigation and would have additional information. During an interview on 4/23/2025 at 2:20 p.m., the Administrator stated she was coming from the store when she saw the fire department on 4/16/2025, so she went to the facility. She stated the DON was already there and found out Resident #1 had been on the floor with a head injury. She stated the resident had already left the building when she arrived. The Administrator stated she did not know what to think about LVN B's actions. She stated she thought LVN panicked . The Administrator stated during her investigation while talking with her, LVN B knew right away she did not do a good job. She stated LVN B told her (Administrator) what she did wrong. The Administrator stated LVN B stated she should not have moved or lifted the resident but there was blood gushing, so she was aware. The Administrator stated if LVN B could call the MD or the DON, she could have called 911 right away. The Administrator stated there was a delay in care. The Administrator stated LVN B did not neglect the resident because she stayed with her and was helping her. The Administrator stated it was lack of judgement on LVN B's part because she should not have moved a resident with a head injury, and she should have called 911 right away. The Administrator stated after the incident, LVN B was counseled on her clinical judgement to ensure she knew what she did wrong. The Administrator stated she consulted with the Medical Director about the incident to get clear direction for how to go forward. She stated based on the Medical Directors recommendation she educated LVN B on trauma and gave her additional training on the protocol that should have followed. The Administrator stated she monitored the staff by ensuring they were trained through in-service training, competency checks and the ADON, DON and herself met with staff daily and told them the Administration all lived across the street and were available 24/7 (24 hours a day, 7 days a week), so they knew the staff had the support. The Administrator stated LVN B was not scheduled for the two days following the incident and was counseled and retrained. The Administrator stated LVN B did not have any prior disciplinary action and no resident complaints. The Administrator stated to correct the incident the facility did the following, completed 4/22/2025 prior to state surveyor entrance: 1. Consulted with the Medical Director on 4/18/2025 for guidance on the incident which included: training of staff on first aide care and a protocol/procedures for First Aide and Response to Head Trauma protocol was approved. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. A consultation of counseling and training was provided on 4/18/2025 to LVN B to ensure she understood what she did wrong. The training included training on first aide care to resident with head injuries. The training on first aide care to residents included not moving the resident and notifying 911 immediately. 3. An in-service training was provided to licensed staff on 4/18/2025 titled Training on First Aide and Response to head Trauma. 4. Information was added to the electronic medical records with instructions for licensed staff response to a head injury. 5. An in-service was provided to all direct care staff assigned to Resident #1 post hospitalization completed on 4/22/2025 to included how to care for a resident in a c-collar and spinal stabilization during care . During interviews on 4/23/2025 8 CNA (CNA's D, E, F, I, J, K, L and M) and 3 LVN (LVNs C, G, and H) staff stated they received the in-service training on fall prevention which included ensuring needed supplies were gathered prior to initiating care and residents should not be left unattended during care, residents should utilize appropriate non-slip footwear, have a call light within reach . CNAs stated they should immediately notify the charge nurse without moving the resident. The licensed staff stated they should notify 911 immediatley without moving the patient after assessment for a resident with a head injury. During interviews on 4/23/2025 interviews with four licensed staff (LVN B, C, G and H)evealed they received the in-service training on First Aide and Response to Head Trauma protocol. They stated they were trained not to move a resident with a head injury, ask for assistance and immediately notify 911 to prevent further injury. During an interview on 4/23/2025 at 2:57 p.m., the Medical Director stated Resident #1 should have been left on the floor and EMS should have been summoned immediately. He stated he agreed the facility should not have lifted the resident or delayed care. He stated a resident with a visual impairment and cognitive impairment would have a significantly increased risk for falls. He stated staffing at the facility was adequate and not an issue. He stated the issue was an employee issue as to why it occurred. He stated he had no concerns for neglect at the facility. The Medical Director stated confirmation that he had discussed the incident and what should have occurred with the Administrator. Record review of an in-service training, dated 4/17/2025, reflected it was completed by 101 of 105 staff (4 staff on leave) which included ensuring all proper supplies were gathered prior to care and including not leaving a resident unattended. The training included: common causes of nursing home falls, common protocols for preventing nursing home falls which included implementation of a resident-centered fall prevention plan. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an in-service training, dated 4/18/2025, reflected 20 of 22 licensed staff (2 staff on leave) had signed they had completed the in-service training for Head Trauma and First Aide which included: Call 911 for someone who has a serious head injury, facial bleeding, bleeding or fluid leakage from the nose/ears, change in consciousness for longer than a few seconds, no breathing, confusion, agitation or restlessness that continues to get worst, loss of balance, weakness or not being able to use an arm or leg, one pupil bigger than the other, slurred speech, seizures. The training also included: keep the person still, do not move the person unless necessary and avoid moving the person's neck. Stop any bleeding, watch for changes in breathing and alertness. Record review of an in-service training, dated 4/22/2024 and ongoing as new staff assigned to care for Resident #1, reflected, the staff were trained on caring for a resident in a c-collar and keeping the spine aligned during care which was provided to 18 staff members on all shifts. The in-service included the following: 1. Ensure the resident does not flex, extend, or rotate the neck. 2. Maintain strict spinal precautions at all times with staff assistance x 3 3. Do not remove the c-collar. 4. Log rolling the resident for all turning and repositioning. Record review of a untitled document, dated 4/18/2025, the Administrator documented on 4/18/2025 at 9:00 a.m., she had a meeting with the facility's Medical Director to review and approve the protocol and procedures for First Aide and Response to Head Trauma. She wrote it was established that a call to 911 should be placed immediately after finding resident on the floor. First Aide for Head Trauma was approved. Record review of the facility's, undated, policy, titled Fall Prevention reflected: Steps in the procedure after a fall: 1. If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities. 2. If there is evidence of a significant injury such as a fracture or bleeding, nursing staff will provide appropriate first aide. 3. Once as assessment rules out significant injury, nursing staff will help the resident to a comfortable sitting, lying, or standing position and then document relevant details. 4. Nursing staff will notify the resident's attending physician and family in an appropriate time frame. When a fall results in a significant injury or condition change, nursing staff will notify the attending physician and Administrator immediately by phone .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 4 residents (Resident #1), reviewed for quality of care. The facility failed to supervise Resident #1 when she was left unattended during care while CNA A retrieved supplies and resulted in a fall with a head injury, scalp laceration, hematoma/contusion to the forehead/scalp, traumatic subarachnoid hemorrhage and fracture to the C-1 vertebrae of her neck. An Immediate Jeopardy (IJ) was identified as past non-compliance on 04/23/25. The noncompliance began on 4/16/2025 and ended on 4/22/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of accidents, and could result in serious injury, harm, impairment, and death. The findings were: Record review of Resident #1's face sheet, dated 4/22/2025 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: history of falling, altered mental status and unsteadiness on feet. Record review of Resident #1's initial History and Physical report dated 11/14/2024 revealed the resident was alert and oriented x 2, legally blind, wheelchair dependent and needed assistance with all ADL's. Record review of Resident #1's Care Plan last revised 11/21/2024 revealed she required assistance with mobility, positioning, transfers in bed, wheelchair, and walker, personal hygiene including bathing, dressing, grooming and hygiene. The Care Plan indicated Resident #1 utilized a bed hand rail x 1 to assist with transfers. Record review of Resident #1's Care Plan last revised 11/21/2024 revealed she was at risk for falls and injury related to impaired physical mobility, impaired vision, and history of falling with interventions which included anticipate and assist with ADLs, assist with transfers, call light in reach and ensure proper footwear. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS of 99 which indicated a severe cognitive impairment with both long- and short-term memory problems and was severely impaired. The assessment indicated Resident #1 was dependent on staff for all ADL care and substantial assistance for movement. (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 Resident #1's Fall Risk assessment dated [DATE] revealed she was at High Risk for falls due to the following contributing factors: intermittent confusion, history of 1-2 falls in past 3 months, chair bound with a note the resident could rise from chair with use of arms, legally blind, taking 3-4 medications considered at risk for falls, and had 1-2 predisposing diseases that increased the risk of falls. Record review of Resident #1's nurse progress notes dated 4/16/2025 at 6:30 p.m., stated a CNA (CNA A) informed LVN B the resident was on the floor. LVN B noted Resident #1 lying next to her bed with the wheelchair at the foot of the bed. The resident had a laceration on the scalp with a large amount of bleeding. Towels were applied on the scalp to stop the bleeding. LVN B further documented the resident was turned and a sling was positioned under her. Resident #1 was then transferred to bed with a mechanical lift. LVN B documented Resident #1 refused ice on the laceration to the scalp and the mass above her right eyebrow that was greater than 5 cm. LVN B documented vital signs of 182/120 (normal 120/80 or lower) HR 91 (normal 60-100), respirations 22 (normal 16-29), temperature 97.3, oxygen saturation 92% (normal 90-100) on room air. LVN B documented Resident #1 refused neuro checks to be done and she responded to verbal stimuli with clear speech to answer yes/no questions. Record review of Resident #1's nurse progress notes dated 4/16/2025 at 7:00 p.m. written by LVN B revealed Resident #1's physician was informed of the resident's condition with orders to send to the hospital for head trauma. Record review of Resident #1's progress notes dated 4/16/2025 at 7:45 p.m., LVN B documented EMS arrived and was transferred to the hospital. Record Review of Resident #1's hospital record revealed she was treated a laceration to scalp requiring 6 sutures (stitches) and 5 staples to close, multiple traumatic subarachnoid hemorrhages, and a C1 [NAME] fracture as a result of an unattended fall at the NF. During her hospital she had a CT head scan which revealed: 1. Focal subarachnoid hemorrhage (bleeding in the space that surrounds the brain and is considered a medical emergency) 2. Acute C-1 cervical vertebral fracture/Jefferson fracture (fracture of the first spinal vertebrae) 2. Contusion/hematoma of right front scalp (bruising and swelling). During her hospital stay a follow up CT scan showed slight enlargement of the bleed (subarachnoid) with multiple new small subarachnoid bleeds, new edema (swelling) to the C1 fracture area, edema noted to other parts of the spine concerning for subtle compression fractures requiring ICU (intensive care) observation and care. Resident #1 was started on the medication Keppra (anti-convulsant medication) as a seizure prophylaxis (to prevent the occurrence of seizure activity). Record review of CNA A's Consultation Form, dated 4/21/2025, revealed a finding of fall with neglect when CNA A left Resident #1 on the bed and went to the bathroom to get a towel that was unintentional. The document indicated CNA reported she transferred the resident to bed; the resident was sitting on the bed while holding the handrail. CNA A turned and walked away a little toward the bathroom when she heard a loud thump, when she returned Resident #1 was on the floor. The form indicated CNA A notified the nurse immediately. The form indicated Resident #1 should not have left the resident unattended and the fall could have been prevented. The form indicated CNA A was re-educated on the facility's procedure on safe transfer and handling a resident with limitations. Record review of a facility document titled Investigation: Injury of Unknown Source, dated 4/17/2025, revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Francis Nursing Home	630 W Woodlawn Ave San Antonio, TX 78212

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 4/16/2025 at 6:34 p.m. security cameras showed CNA A entered the resident's room. Per the CNA's statement she left resident at bedside while she retrieved items from the bathroom in the room. CNA A heard fall and returned immediately to room. -On 4/16/2025 at 6:38 p.m. security cameras show CNA A rush from room and return with LVN B, eleven seconds later. -At 7:45 p.m. EMS arrived and transported Resident #1 by stretcher to a local hospital. Record review of a written statement by CNA A (undated) revealed on 4/16/2025 around 7:30 p.m., she took Resident #1 to the room getting her ready for bed, she indicated she sat the resident on the bed and went to grab a washcloth from her restroom when all of a sudden, she heard a loud fall. CNA A wrote she saw the resident on the floor and went to grab LVN B quick. During an observation and interview on 4/22/2025 at 11:30 a.m., Resident #1 was observed at a local hospital. She was in bed with a hard c-collar in place. Her eyes were puffy and swollen and she was unable to fully open them. She had a bandage in place at the top of her scalp where the forehead met the hairline. She had severe bruising to her forehead with noted swelling to the forehead. She had bilateral peri -orbital bruising (bruising around both eyes). All bruising was noted to be black and varying shades of purple with some dark shades of yellow/green near the edges. Resident #1 attempted to open her eyes when spoken to. She acknowledged she was being spoken to but was unable to answer any interview questions. She responded by making noises and grunting only. During an observation and interview on 4/23/2025 at 10:35 a.m., Resident #1 was observed in bed at the nursing facility. The head of her bed was elevated to 75 degrees. She had on a hard c-collar. Her face was bruised in varying shades of black, purple, green, and yellow with the largest portion of bruises noted to her forehead and eyes and mid-face. She had a bandage to her upper forehead and swelling to the upper forehead. Resident #1's bed was in low position with a staff member at bedside. Resident #1 did not respond responded with grunts and sounds only when spoken to. During an interview on 4/22/2025 at 7:05 p.m., Resident #1's RP stated he was notified on 4/16/2025 at 7:15 p.m. by an unknown nurse that his family member had fallen from her wheelchair, hit her head and was on the way to the hospital. He stated he had concerns about the seriousness of Resident #1's injuries which he stated he had discussed with NF head staff. He stated Resident #1 would return to the facility today (4/22/2025). During an interview on 4/23/3035 at 11:48 p.m., the SW stated she participated in the investigation of Resident #1's fall injury. She stated she interviewed other residents on the unit (safe surveys). She stated she asked how everyone was treating them and if they felt safe. She asked specifically about care provided after noon and dinner shift. She started she asked about CNA A and LVN B and if there were any patterns to care. She stated during her investigation no concerns were voiced about care or about CNA A or LVN B. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/23/2025 at 12:31 p.m., CNA A stated she took Resident #1 to her room to put her to bed on 4/16/2025. She stated she put Resident #1 on the bed and removed the wheelchair. She stated she left Resident #1 sitting near the (hand) rail with her legs handing off the bed but her feet kind of touching the floor. CNA A stated she then walked away to get a towel from the bathroom, realizing there were none and heard a big sound. CNA A stated she did not think Resident #1 was going to fall. CNA A stated Resident #1's bottom was not all the way on the bed, but on the edge and little further back. CNA A stated Resident #1 usually held the handrail, but she did not know if the resident was holding it. CNA A stated she thought Resident #1 was going to hold the handrail but was not certain if she grabbed it and let go or not. CNA A stated she heard the fall. CNA A stated she was so scared and ran and got LVN B. She stated she told LVN B to hurry and she came right away. CNA A stated they found her on the floor. She stated Resident #1's arms looked twisted, with one arm under her body and the other one with the wrist bend. CNA A stated she did not know what happened or how Resident #1 hit the floor. She stated she did not see the fall; she just heard it. CNA A stated Resident #1 did not call out before the fall. She described the resident as not able to talk. She stated the resident just says, no no no and was confused. CNA A stated Resident #1 was blind and was not able to see at all. CNA stated she also noted blood by Resident #1's head, like a little pool of blood. CNA A stated she did not see any other injuries because LVN B stated she did not need anything else and she left the room. She stated she saw LVN B take vitals signs and they helped Resident #1 back to bed by use of a mechanical lift. CNA A stated she was trained in fall prevention. She stated there was an in-service every month. She stated she received training and counseling after the incident as well. CNA A stated she was taught to be careful with people and make sure to do the right thing. She stated she reviewed transfers and making sure the resident had a safe place where they could not fall. She stated she was also trained to wait for the resident if they were using the toilet or were somewhere they could fall. CNA A stated she was in a hurry because she had other people to put in bed. She stated she was not thinking about a fall, she just moved away, and Resident #1 fell . CNA A stated she felt so ugly that this occurred because Resident #1 was in her care. She stated she could not believe it happened and it was her fault. CNA A stated going forward she would be very very careful with everyone and was not going to rush. CNA A stated after the fall occurred the Administrator told her next time, never leave a resident like that and to always think about the worst things that could happen. CNA A stated the Administrator counseled her to be more careful and to make sure she was safe before leaving the room. CNA A stated she also received a training on how to care for Resident #1 now that she was back from the hospital. She stated they had to roll her because of her neck and her spin had to always be in alignment. CNA A stated two CNAs and a nurse had to supervise so that three people all at the same time cared for her, so she was safe. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/23/2025 at 12:50 p.m., LVN B stated on 4/16/2025 at 6:30 p.m., CNA A came shouting in the hallway that Resident #1 was on the floor. LVN B stated she went immediately and found Resident #1 next to the bed with the wheelchair at the foot of the bed. She stated Resident #1 had excess bleeding. LVN B stated at 7:40 p.m., Resident #1 was transferred by EMS to the hospital. LVN B stated Resident #1 was not able to move by herself because of weakness on her right side. She stated she did not move by herself. LVN B stated she asked CNA A what happened, and CNA A stated she turned to get a towel and Resident #1 fell . LVN B stated her expectation of the CNA was for her to bring the resident to the nurses' station or ask for assistance if she forgot something so Resident #1 would be supervised for her safety. LVN B stated she received training post incident on fall prevention which included not leaving residents unattended. LVN B stated she also received training on resident's with head injuries and first aide training which included not moving the resident and calling 911 as soon as possible. LVN B stated she received a training for caring for Resident #1 after returning from the hospital which included repositioning, log rolling, not moving her without assistance. During an interview on 4/23/2025 at 1:46 p.m., the DON stated Resident #1 was blind, mostly responded to yes/no questions and was confused. The DON stated on 4/16/2025 Resident #1 had a very bad accident while CNA A was caring for her. The DON stated according to CNA A's statement the resident fell while sitting on the bed. The DON stated CNA A acknowledged she left the resident unattended. The DON stated the next day (4/17/2025) she learned the severity of Resident #1's injuries. The DON stated the CNA was negligent in leaving the resident unattended. She stated no one should be left on the edge of the bed. The DON stated she did not know why it occurred because Resident #1 did not move and did not stand up. She stated it was so unexpected because the resident normally obeyed and stayed put. The DON stated Resident #1 was a fall risk and required one staff person for assistance. The DON stated she thought CNA A would change what had occurred if she could. The DON stated her expectation of staff was to never, ever leave a resident unattended if they were not ready and prepared to provide care. The DON stated it would have taken just a second to put Resident #1's legs on the bed. She stated fall precautions were important because of the risk for falls. The DON stated the facility wished it had never happened, but they worked to provide in-service training to all staff on fall precautions which included never leaving a resident unattended. The DON stated all staff had been educated on 4/18/2025 with the exception of 4 staff who were on leave and not available. The DON stated the SW and Administrator would have additional information about what was done to correct the situation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/23/2025 at 2:20 p.m., the Administrator stated on 4/16/2025 she saw the fire department at the facility, so she went to the facility. She stated the DON was already there and she learned Resident #1 had been on the floor with a head injury. The Administrator stated she immediately started an investigation because she was told it was an unwitnessed fall by CNA A. She stated as she investigated, she found that CNA A was not with Resident #1 when she fell and CNA A only heard a loud thump, turned and found the resident on the floor. The Administrator stated she interviewed CNA A in person. She stated CNA A was in distress and stated originally that Resident #1 had fallen from her wheelchair, and she thought the resident misunderstood her and was trying to get up. The Administrator stated she interviewed staff about how the resident transfers and how she stood up and if she was able to move at all. The Administrator stated after talking to Resident #1's family member who told her the resident was unable to get up and other CNAs who stated she followed direction and was afraid to get up, she called CNA A to discuss the incident again. The Administrator stated CNA A told her she was in shock originally and admitted to leaving the resident sitting on the edge of her bed and walking away. The Administrator stated CNA A said she was going to get washcloths. The Administrator stated she told CNA A that was not how we did it. She stated she asked CNA A if she did it on purpose or had ill intentions. She stated CNA A said no and was very upset. She stated she did not know what she was thinking. The Administrator stated CNA A stated Resident #1 never moves but she was aware she was not supposed to leave the resident like that. The Administrator stated she was not supposed to walk away from the resident. She stated CNA A had been a CNA for a long time and stated I do not know what got into her. She made a wrong judgement. The Administrator stated she told CNA this could not happen. She stated she completed an investigation prior to the state surveyors arrival on 4/22/2025 and found she was not neglecting other residents and she was allowed to come back to work after two days because she believed CNA A had an error of judgement. The Administrator stated she consulted with the Medical Director about the incident. She stated she educated staff on fall precautions, trauma and first aide and made sure the facility had a protocol that could be followed. The Administrator stated she monitored staff by providing training and in-services, by competency checks and daily meetings where the ADON, DON and herself met with staff daily and talked to them. The Administrator stated the administration team lived right across the street and they ensured staff knew they were available 24/7 (24 hours a day, 7 days a week) so the staff knew they were supported. The Administrator stated CNA A had no prior disciplinary issues, was reliable and had no resident complaints. She stated CNA A had not been scheduled for two days after the incident and was counseled and retrained. The Administrator stated the following actions were immediately taken by the facility to correct the action which was completed on 4/22/2025 prior to the state surveyor arrival. They included: 1. Same day in-service on fall prevention to all staff 101 of 105 (4 staff on leave) which included ensuring all proper supplies were gathered prior to care and included not leaving residents unattended. 2. A consultation of counseling and training was provided on 4/21/2025 to CNA A to ensure she understood what she did wrong. The training included facility procedures for fall precautions, safe transfers, handling residents with limitations which included not leaving residents alone when providing care. 3. A protocol was developed and training provided to CNA staff on fall precautions, ensuring things were set up before providing care and never leave the resident unattended . (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 an in-service training dated 4/22/2024 and ongoing as new staff assigned to care for Resident #1 revealed, the staff were trained on caring for a resident in a c-collar and keeping the spine aligned during care which was provided to 18 staff members on all shifts. The in-service included the following: 1. Ensure the resident does not flex, extend, or rotate the neck. 2. Maintain strict spinal precautions at all times with staff assistance x 3 3. Do not remove the c-collar. 4. Log rolling the resident for all turning and repositioning. Record review of an untiled document dated 4/18/2025, the Administrator documented on 4/18/2025 at 9:00 a.m., she had a meeting with the facilities Medical Director to review and approve the protocol and procedures for First Aide and Response to Head Trauma. She wrote it was established that a call to 911 should be placed immediately after finding resident on the floor. First Aide for Head Trauma was approved. Record review of the facility's, undated, policy, titled Fall Prevention revealed: Residents who have a history of frequent falls or have high risk factors for falling will be identified in an effort to prevent falls. All residents will be assessed for risk of fall upon admission, with reassessments routinely performed to determine ongoing need for fall prevention precautions. Any resident determined to be at risk for fall will be placed on fall prevention precautions. Residents in the fall prevention program will be closely monitored.