STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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 - Few	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** 49640 Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for one of three halls (Hall 300) observed for daily living safely. The facility failed to ensure a shared bathroom on hall 300 was clean and sanitary for rooms [ROOM NUMBERS]. The facility failed to ensure a clean and sanitary mattress for Bed B in room [ROOM NUMBER]. This failure could place residents at risk for diminished quality of life due to the lack of unsanitary and unclean environment. Findings include: Observation on 07/16/2024 at 10:00 a.m., revealed a strong smell of urine from room [ROOM NUMBER]. Observation of Bed B revealed a sheetless mattress with a strong smell of urine which contained a wet circle. Observation of the shared bathroom with rooms [ROOM NUMBERS], revealed dried feces spread around the toilet seat and no toilet paper. Loose paper was observed on the floor in front of sink. Observation on 07/16/2024 at 11:30am revealed a strong smell of urine from room [ROOM NUMBER]. Observation of Bed B revealed a sheetless mattress with a strong smell of urine which contained a wet circle. Observation of the shared bathroom with rooms [ROOM NUMBERS], revealed dried feces spread around the toilet seat and no toilet paper. Loose paper was observed on the floor in front of sink. Interview on 07/16/2024 at 11:19am with CNA G revealed housekeeping normally cleaned the secured unit once in the morning and once in the afternoon. Interview on 07/16/2024 at 1:57pm with Housekeeper A revealed he was reassigned to the laundry room by the Maintenance Director. Housekeeper A stated he didn't clean any halls this day. An interview with the Maintenance Director on 07/16/2024 at 3:05pm revealed unit 300 wasn't cleaned because he reassigned Housekeeper A, who normally cleaned the hall, to laundry. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/16/2024 at 1:45pm with the Administrator revealed the units are cleaned daily. The Administrator stated the Housekeeper is expected to spot check each room on their assigned unit before leaving. The Administrator stated the Housekeeping Manager left early today due personal leave . Interview on 07/19/24 at 1:32 PM with the Housekeeping Supervisor revealed on Tuesday (07/16/24) she had to leave early. She stated she expected housekeeping to clean the secure unit rooms (hall 300) including bathrooms twice daily. She stated she found out Housekeeper A, who was supposed to clean on the secure unit, was pulled to work in Laundry his entire shift. She stated housekeeping services should have occurred for residents on the secure unit so it can be cleaned. She stated she or the housekeeper who was pulled to laundry clean the secure unit on their shift. Record Review of facility's Policy Quality of Life - Homelike Environment last revised April 2014 reflected Residents are provided with a safe, clean, comfortable and homelike environment The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect personalized homelike setting. These characteristics in: a. Cleanliness and order .

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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 - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 49427 Based on observations, interview and record review, the failed to implement their written abuse prevention policy and investigate allegations for two residents (Residents #1 and #8) of eight residents reviewed for resident abuse and one (LVN B) of three staff files reviewed for employee files. 1. The Administrator failed to follow facility policy when Resident #1 had an injury of unknown origin resulting in serious injury by not reporting the injury within the required timeframe. 2. CNA H failed to immediately report an allegation of abuse to the Administrator or DON related to Resident #8. 3. Facility failed to ensure LVN B's Criminal Background Check and EMR/NAR check were completed upon hire and in her employee file. These failures places residents at risk of abuse along with allegations of abuse identified and investigated thoroughly. Findings included: Record Review of facility's policy for staff reporting abuse allegations dated 2001 and revised January 2011 titled Policy for Reporting Abuse to Facility Management: Responsibility of Reporting Resident Abuse reflected: It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse .to facility management . Responsibility of Reporting Resident Abuse 4) Employees, facility consultants and/or attending physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management . Requirements to Report 6) Any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Review of facility's Abuse and Neglect Reporting Policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 2001 and revised September 2022, reflected: (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 - Some	All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . Reporting Allegations to the Administrator and Authorities 1.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. 2.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 1. Review of Resident #1's face sheet dated 07/16/2024 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of traumatic brain injury, type-2 diabetes, hypertension (high blood pressure), muscle weakness, cognitive communication deficit, anxiety disorder and depression disorder with a BIMS score of 00 (severely impaired cognition). Review of Resident #1's care plan revealed Resident #1 had a problem regarding falls with a start date of 06/19/2023 and edited date of 06/11/2024. The care plan noted that Resident #1 had a history of falls with no injuries, and the fall dated 02/24/2024 did not indicate if the resident had any injuries and stated self transfer. with a long-term goal to reduce number of falls and be free from significant injury. Interventions included floor mats next to bed when resident was in bed, ensure her nonskid socks are on, floor mats on floor when resident is in bed, and check frequently to make sure resident was not self-transferring, (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 - Some	Observation on 07/16/2024 at 9:40 AM of Resident #1 revealed she was asleep in bed on low position and with floor mats and interview with resident revealed she was confused, pleasant, and did not remember falling. Review of Event Report for Resident #1 by LVN A with an event date of 02/24/2024 12:17 AM and completed date of 02/26/2024 at 1:38 PM by the DON revealed resident was confused, agitated and placed to bed several times when a CNA found resident on the floor lying on her right side pain and was mumbling & grumbling during transfer with X-ray to both hips ordered and resident's POA, supervisor, and physician notified. Review of Resident #1's nurse's progress note dated 02/24/2024 at 1:48 AM by LVN A revealed resident had an unwitnessed fall and the Physician, supervisor, and resident's representative were notified and a STAT x-ray to both hips were ordered. Review of Resident #1's nurse's progress note dated 02/24/2024 at 10:11 AM by LVN B reflected 9am Resident has facial grimacing and has been holding her left hip. [Physician C] notified ordered [Tylenol] 500mg tablet one q 4hrs prn pain.[Tylenol] 500mg tab one given for pain inital [sp] dose given for pain for pain level of 5. Repositioned in bed with both legs in straight alignment using pillows to keep legs straight align ment.10am good results from pain med.(1) 1011am Phone call made to [X-ray Company N] and they said he will be here shortly. Review of Resident #1's nurse's progress note dated 02/24/2024 at 12:27 PM by LVN B revealed at 12:24 PM [x-ray company N] had arrived to x-ray resident's hips and resident was observed moaning and holding her left hip and was given a Tylenol 500 mg for a pain level noted as a 4 and was turned and repositioned with pillows. Review of Hospital EMS record dated 02/24/24 reflected EMS received a phone call on 02/24/24 at 5:02 PM from facility. Resident #1 was transported from facility to local hospital for a possible hip fracture. Patient was having right hip pain secondary to a fall she sustained at 0100 this morning. Nursing staff stated they called for transport due to the patient not getting better. Patient was transported supine and immobilized the right hip area. Patient also has a history of [traumatic brain injury] due to a fall and hitting her head on a marble coffee table as stated by family in the room .Patient complains of pain on the left side during any movement . Lower extremities-patient had pain on left side with shortening of the left leg The EMS record reflected Resident #1 had chief complaint of hip hurting for 16 hour duration. Review of Resident #1's nurse's progress note date 02/24/2024 at 7:21 PM by LVN B revealed Resident #1's family had visited and were told the x-ray results were not in yet and staff had called x-ray services and they stated it would be awhile until results were ready. LVN B documented that the POA wanted Physician C called to ask for an order to transfer Resident #1 to the hospital via ambulance to be evaluated by the emergency room doctor. LVN B documented that Physician C gave orders to send Resident #1 to the hospital and Resident #1 was being transported via ambulance at 5:00 PM and DON notified at 5:09 PM. Record review of Resident #1 x-ray report titled Patient Report with date of service of 02/24/2024 and electronically signed by Physician E on 02/24/2024 at 7:55 PM reflected Resident #1 had both her left and right hips x-rayed and she had an acute left hip fracture. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Email received from X-ray Company N dated 07/16/24 at 4:38 PM sent to ADON revealed the X-ray Company N notes indicated received phone call from [LVN A] at 4:01 AM who took the order. It was originally placed as routine. [LVN B] called at 10:21 AM and the order was changed to a STAT. [X-ray tech] called facility at 10:40 am and spoke to [LVN A] with ETA. [X-ray tech] arrived at 12:15 PM . Review of provider investigation report dated and signed by the Administrator on 03/01/2024 revealed Resident #1's fall was reported to HHSC on 02/25/2024 at 9:10 AM. Interview on 07/16/2024 at 12:58 PM with DON revealed she was unsure when the x-ray report was received by the facility and would have to go look at the Provider Investigation Report (PIR). The DON reviewed the PIR and stated that it looked like it was received by the facility on 02/24/2024 at 8:00 PM. The DON stated she did not remember the incident well because it happened during the weekend and she was not working. She stated it also happened in February 2024 and it was difficult for her to remember the details because she did not work on that weekend but stated she knew the Administrator was aware and was handling the investigation. Interview on 07/17/24 at 9:05 AM with DON revealed Resident #1 was sent out to the hospital on 02/24/24 at 5:09 PM because the facility had not received the stat x-ray results and according to the provider investigation report the resident had pain. The DON stated she did not review Resident #1's stat x-ray results until 02/25/24 and she did receive an email in the evening about a critical x-ray result indicating Resident #1 had a hip fracture but she did not review it until the next morning. She stated Resident #1's stat x-ray results were not received until after Resident #1 was sent to the hospital. She stated she was not sure when the Administrator reported the fracture to the state. Interview on 07/22/24 at 2:44 PM with the Administrator revealed Resident #1's fracture should have been reported to the state within 2 hours. She stated there was a delay in reporting to the state. She stated Resident #1 had a fracture and she was not aware of it until the next morning (02/25/24) when the DON reported it to her. She stated she was not aware the DON had received an email about the critical x-ray showing Resident #1 had a hip fracture the evening before. She stated the risk to residents due to a delay in reporting allegations of abuse and neglect could place residents at risk of further abuse and neglect. 2. Record Review of Resident #8 's, face sheet revealed he was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of encephalopathy (a brain disease that alters brain function), hypertension (high blood pressure), dysphagia, unspecified dementia (impaired ability to remember, think, or make decisions), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder (persistent feelings of worry), metabolic encephalopathy (a neurological disorder), hyperlipidemia (high levels of fat particles in the blood), unspecified, hypothyroidism (deficiency of thyroid hormones), muscle weakness, and aphasia (language disorder). Record review of Resident #8's discharge MDS dated [DATE] revealed he had a BIMS score of 10 (moderate cognitive impairment). Record Review of a witness statement dated 09/26/2023 signed by CNA H revealed LVN M pulled Resident #8 from a chair by his legs causing Resident #8 to fall. CNA H indicated the incident occurred on 09/25/2023 at approximately 5:20pm. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Progress Notes dated 9/26/2023 at 1:02am indicated multiple bruises notes to Resident #8's bilateral arm. Resident #8 denied pain at the site. Medications administered as ordered and well tolerated. An interviewed with CNA H via telephone on 07/16/2024 at 2:12pm revealed after witnessing an incident between Resident #8 and LVN M, it wasn't reported until the next morning. CNA H stated she knew to report abuse immediately, but the incident happened at the end of her shift at approximately 5:30pm. CNA H stated as a temporary employee, she didn't have a telephone number or anyone to report it to. CNA H stated she reported the incident the next morning to the DON and the Administrator. CNA H stated LVN M was the only nurse on the unit, and she was in and out of the unit. CNA H stated she couldn't leave the secured unit for this reason since LVN M was the only nurse on the unit and there was no one else to report to. An interview with the DON on 07/16/2024 at 3:20pm revealed CNA H informed her of the abuse allegation the morning after the incident. The DON stated she was unsure of the exact time, but it was in the morning. The DON stated she and CNA H reported the incident to the previous Administrator. She stated she doesn't know why it took a while for the previous Administrator to self-report. An interview with the Administrator 07/16/2024 at 6:25pm revealed according to policy, abuse should be reported within 2 hours. The Administrator stated as the Abuse Coordinator, her contact information was posted in several places throughout the facility. 3. Review of facility's policy Abuse Prevention Program revised November 2010 reflected Our facility conducts employee background checks .Screening: The facility will screen employees for a history of abuse, neglect, or mistreating resident by .checking with the appropriate licensing boards and registries. Review of LVN B's employee file revealed a hire date of 07/01/22 with no criminal background check and EMR/NAR check in employee file. Interview on 07/19/24 at 6:01 PM with Administrator revealed she could not find the criminal background checks and EMR/NAR for LVN B. She stated HR Manager was not at facility so she will follow up with HR Manager to see if she can find LVN B's criminal background check and EMR/NAR for LVN B. The Administrator stated she would run the EMR/NAR checks and Criminal background checks for LVN B. Interview on 07/22/24 at 1:15 PM with HR Manager revealed she was not able to locate EMR/NAR checks and criminal background checks for LVN B. She stated the risk for residents would be having employees providing care to residents who have abusive background. She stated the criminal background check for LVN B should have been completed prior to hire and should be in the file. She stated she found out within the last month that EMR/NAR checks need to be completed upon hire and annually. She stated she did not know the criminal background checks and EMR/NAR checks were missing in some of the employee files who were not new hires. She stated as the HR manager with the new hires the EMR/NAR checks along with criminal background checks are completed prior to employee being hired. She stated she did not receive much training before she was put in this position. She stated she will check the current employees who are not new hires to ensure the criminal background checks and EMR/NAR checks are completed and in the employee files. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Follow-up interview on 07/22/24 at 2:44 PM with Administrator, she said the HR Manager was responsible to ensure employee criminal background checks and EMR/NAR checks were completed. She stated the criminal background checks should be completed upon hire and kept in employee file. She stated not having EMR/NAR checks completed and Criminal background checks completed place residents at risk of harm and abuse if employees have bars to employment the facility should have been aware of. She stated she was not aware LVN B's criminal background check and EMR/NAR check were not in her employee file. She stated she would have to follow up with HR to ensure upon hire for employees to have criminal background checks completed and EMR/NARs upon hire/annually in employee files. Review of LVN B's EMR/NAR check completed on 07/18/24 after surveyor intervention revealed she was employable. Review of LVN B's Criminal Background completed on 07/19/24 after surveyor intervention revealed no bars to employment. Review of facility's policy Section II: Hiring - Pre-Onboarding the New Employee undated reflected .EMR (Employee Misconduct Registry) The Employee Misconduct Registry is a public registry that collects data on unlicensed personnel who commit acts of abuse, neglect, exploitation, misappropriation, or misconduct against residents and consumers. Its purpose is to identify and prevent employability for anyone on the list. HHSC-regulated facilities and agencies are required to check this list before the first day of employment and annually thereafter .Every Employee must have a Criminal Background Check performed and results received prior to beginning work at the facility . 49640

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interview and record review, the failed to report allegations of abuse within 2 hours to HHSC for abuse allegations for two residents (Residents #1, #8 and) of 8 residents reviewed for reporting resident abuse. 1. The Administrator failed to report Resident #1's fall with serious injury within 2 hours to HHSC. 2. The facility failed to report an allegation of abuse involving Resident #8 to the appropriate State Agency immediately on 09/25/2023. These failures could place resident at risk of not having abuse, neglect, exploitation allegations reported. Findings include: 1. Review of Resident #1's face sheet dated 07/16/2024 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of traumatic brain injury, type-2 diabetes, hypertension (high blood pressure), muscle weakness, cognitive communication deficit, anxiety disorder and depression disorder with a BIMS score of 00 (severely impaired cognition). Review of Resident #1's care plan revealed Resident #1 had a problem regarding falls with a start date of 06/19/2023 and edited date of 06/11/2024. The care plan noted that Resident #1 had a history of falls with no injuries, and the fall dated 02/24/2024 did not indicate if the resident had any injuries and stated self transfer with a long-term goal to reduce number of falls and be free from significant injury. Interventions included floor mats next to bed when resident was in bed, ensure her nonskid socks are on, floor mats on floor when resident is in bed, and check frequently to make sure resident was not self-transferring, Observation on 07/16/2024 at 9:40 AM of Resident #1 revealed she was asleep in bed on low position and with floor mats and interview with resident revealed she was confused, pleasant, and did not remember falling. Review of Event Report for Resident #1 by LVN A with an event date of 02/24/2024 at 12:17 AM and completed date of 02/26/2024 at 1:38 PM by the DON revealed resident was confused, agitated and placed to bed several times when a CNA found resident on the floor lying on her right side pain and was mumbling & grumbling during transfer with X-ray to both hips ordered and resident's POA, supervisor, and physician notified . Review of Email received from X-ray Company N dated 07/16/24 at 4:38 PM sent to ADON revealed the X-ray Company N notes indicated received phone call from [LVN A] at 4:01 AM who took the order. It was originally placed as routine. [LVN B] called at 10:21 AM and the order was changed to a STAT. [X-ray tech] called facility at 10:40 am and spoke to [LVN A] with ETA. [X-ray tech] arrived at 12:15 PM . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Hospital EMS record dated 02/24/24 reflected EMS received a phone call on 02/24/24 at 5:02 PM from facility. Resident #1 was transported from facility to local hospital for a possible hip fracture. Patient was having right hip pain secondary to a fall she sustained at 0100 this morning. Nursing staff stated they called for transport due to the patient not getting better. Patient was transported supine and immobilized the right hip area. Patient also has a history of [traumatic brain injury] due to a fall and hitting her head on a marble coffee table as stated by family in the room .Patient complains of pain on the left side during any movement . Lower extremities-patient had pain on left side with shortening of the left leg The EMS record reflected Resident #1 had chief complaint of hip hurting for 16 hour duration. Record review of Resident #1 x-ray report titled Patient Report with date of service of 02/24/2024 and electronically signed by Radiologist, Physician E, on 02/24/2024 at 7:55 PM reflected Resident #1 had both her left and right hips x-rayed and she had an acute left hip fracture. Record review of provider report dated 03/01/2024 revealed incident was reported to HHSC on 02/25/2024 at 9:10 AM. Observation on 07/16/2024 at 9:40 AM of Resident #1 revealed she was asleep in bed on low position and with floor mats and interview with resident revealed she was confused, pleasant, and did not remember falling. Interview on 07/17/24 at 9:05 AM with DON revealed Resident #1 was sent out to the hospital on 02/24/24 at 5:09 PM because the facility had not received the stat x-ray results and according to the provider investigation report the resident had pain. The DON stated she did not review Resident #1's stat x-ray results until 02/25/24 and she did receive an email in the evening about a critical x-ray result indicating Resident #1 had a hip fracture but she did not review it until the next morning. She stated Resident #1's stat x-ray results were not received until after Resident #1 was sent to the hospital. She stated she was not sure when the Administrator reported the fracture to the state. Interview on 07/22/24 at 2:44 PM and 2:48 PM with the Administrator revealed Resident #1's fracture should have been reported to the state within 2 hours. She stated there was a delay in reporting to the state. She stated Resident #1 had a fracture and was not aware of it until the next morning (02/25/24) when DON reported it to her. She stated she was not aware the DON had received an email about the critical x-ray the evening before. She stated the risk to residents due to a delay in reporting allegations of abuse and neglect could place residents at risk of further abuse and neglect. 2. Record Review of Resident #8 's, face sheet revealed he was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of encephalopathy (a brain disease that alters brain function), hypertension (high blood pressure), dysphagia, unspecified dementia (impaired ability to remember, think, or make decisions), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety disorder (persistent feelings of worry), metabolic encephalopathy (a neurological disorder), hyperlipidemia (high levels of fat particles in the blood), unspecified, hypothyroidism (deficiency of thyroid hormones), muscle weakness, and aphasia (language disorder). Record review of Resident #8's discharge MDS dated [DATE] revealed he had a BIMS score of 10 (moderate cognitive impairment). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of a witness statement dated 09/26/2023 signed by CNA H revealed LVN M pulled Resident #8 from a chair by his legs causing Resident #8 to fall. CNA H indicated the incident occurred on 09/25/2023 at approximately 5:20pm. Record Review of Progress Notes dated 9/26/2023 at 1:02am indicated multiple bruises notes to Resident #8's bilateral arm. Resident #8 denied pain at the site. Medications administered as ordered and well tolerated. An interview with CNA H via telephone on 07/16/2024 at 2:12pm revealed after witnessing an incident between Resident #8 and LVN M, it wasn't reported until the next morning. CNA H stated she knew to report abuse immediately, but the incident happened at the end of her shift at approximately 5:30pm. CNA H stated as a temporary employee, she didn't have a telephone number or anyone to report it to. CNA H stated she reported the incident the next morning to the DON and the Administrator. CNA H stated LVN M was the only nurse on the unit, and she was in and out of the unit. CNA H stated she couldn't leave the secured unit for this reason since LVN M was the only nurse on the unit and there was no one else to report to. An interview with the DON on 07/16/2024 at 3:20pm revealed CNA H informed her of the abuse allegation of Resident #8 the morning after the incident. The DON stated she was unsure of the exact time, but it was in the morning. The DON stated she and CNA H reported the incident to the previous Administrator. She stated she doesn't know why it took a while for the previous Administrator to self-report. An interview with the Administrator 07/16/2024 at 6:25pm revealed according to policy, abuse should be reported within 2 hours. The Administrator stated as the Abuse Coordinator, her contact information was posted in several places throughout the facility. Review of facility's Abuse and Neglect Reporting Policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating dated 2001 and revised September 2022, reflected: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . Reporting Allegations to the Administrator and Authorities 1.If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law and HHSC reporting guidelines. 2. 2.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3.Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 49640

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49427 Based on observations, interviews, and record review, the facility failed to develop or implement a person-centered comprehensive care plan for one (Resident #2) of five residents reviewed for care plans. The facility failed to provide a comprehensive and person-centered care plan for Resident #2 about resident's behaviors and preferences. This failure puts residents at risk of not being provided personalized care and negatively impact their quality of life. Findings included: Record review of Resident #2's face sheet was a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses of unspecified dementia, bi-polar disorder (intense shifts in mood and energy levels), chronic obstructive pulmonary disease (lung disease causing difficulty breathing), emphysema (lung condition that causes shortness of breath), and alcohol abuse. Review of Resident #2's Quarterly MDS dated [DATE] revealed a BIMS score of 03 (severe cognitive impairment). Record review of Resident #2's care plan revealed problem start date of 10/17/2023 and edited on 06/12/2024 that resident hides cigarettes and lighters in his room with an approach of smoking materials to be kept per facility guidelines and staff provided education regarding smoking policy. Further review revealed a problem start date of 12/16/2022 of potential of complications related to use of psychotropic medications due to diagnosis of Bipolar/Depression and an approach of .Redirect resident when he starts to cuss or yell at staff and other residents. Resident will get upset when he runs out of cigarettes. with an edit date of 06/27/2023. Record review of Resident #2's nursing progress note dated 11/24/2023 by the ADON revealed a vape was found in Resident #2's room and he and family member were educated that resident cannot have vapes in his room. Record review of Resident #2's nursing progress note dated 12/21/2023 by DON revealed resident was found in his room with a vape and was refusing to give it to a CNA. The DON documented that the resident and family member were provided further education on facility policy regarding vapes and that further incidents would result in a 30-day discharge notice. Record review of Resident #2's nursing progress note dated 01/09/2024 by Social Services Director revealed resident was observed by staff smoking a vape in his room and educated family member to bring new vapes directly to facility and they would store the vape in the smoke box. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's nursing progress note dated 07/09/2024 by LVN I revealed resident had two vapes during the smoke break and cursed and yelled at LVN I for asking Resident #2 about having two vapes. Observation and interview on 07/16/2024 at 11:05 AM of Resident #2 revealed he was seated in a wheelchair in the dining room at a table with other residents wearing a bright green hat and t-shirt and pants, he appeared clean with no odors and agreed to private interview and became agitated when exiting the dining room and stated he would be interviewed in the hallway. Interview on 07/16/2024 at 9:58 AM with LVN F revealed that she was familiar with Resident #2 and that he was frequently rude, cussed at staff with profanity and racial slurs, was demanding, and sometimes he rejected care. LVN F stated Resident #2 enjoyed smoke breaks to use his vape. Interview 07/16/2024 at 11:07 AM with Resident #2 revealed that sometimes staff came up to him with a frowning look on their faces and he did not like it and would frown right back. Resident #2 stated he did curse at staff if they made him angry and at other residents because they irritated him because they are not all there in the head. Resident #2 stated the activity he enjoyed the most was the smoke breaks and he had switched from cigarettes to vapes. Interview on 07/19/2024 at 2:37 PM with CNA G revealed she was agency staff and had worked at the facility regularly for about a year and a half. CNA G stated that she was familiar with Resident #2 and he was verbally abusive to staff and other residents and any redirection served no purpose. CNA G stated that they have to keep Resident #2 and another resident separate. CNA G stated that his family had snuck alcohol into the room for the resident and vapes in the past. CNA G stated that smoke breaks are the most important to Resident #2 and if he thought he was going to miss a smoke break due to needing incontinent care then he refused care. Interview on 07/19/2024 at 3:08 PM with CNA N revealed she had worked at facility for about a year and was familiar with Resident #2. CNA N stated that Resident #2 cursed and used racial slurs at staff if they were not able to do what he wanted when he wanted it done. CNA N stated that physical therapy had told Resident #2 to push himself in his wheelchair but he would become angry and lash out at staff and constantly tried to get someone to push him down the hall. Interview on 07/19/2024 at 6:44 PM with CNA O revealed she was familiar with Resident #2 and that he had moments of not being kind, cussed at and used racial slurs towards staff and other residents. She stated that Resident #2 and another resident do not get along so staff monitor them and kept them away from each other. CNA O stated his favorite activity was when he used his vape during the smoke break and talking with other residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 07/19/2024 at 3:20 PM with the ADON revealed she was responsible for acute care plans and had worked at the facility for about 2 years. The ADON reviewed Resident #1's care plan and stated that the care plan showed that resident had a fall on 02/24/2024 with the words self-transfer and instead should say she had the fall on 02/24/2024 with injury of hip fracture due to a self-transfer. The ADON stated she was familiar with Resident #2 and he had challenging behaviors. The ADON stated he was observed using a vape in his room more than once, had alcohol snuck into the facility by visitors multiple times, yelled and cursed at staff and residents over little things or when they did not provide something the minute he asked for it and that they had to be very careful in the way they approach Resident #2 or he will also refuse care. The ADON reviewed Resident #2's care plan and stated that the concerns regarding his behavior of verbal abuse towards other staff and residents, drinking alcohol and sneaking it into his room, and used vapes instead of cigarettes should be in his care plan and would update it right away. The ADON stated she was not sure why Resident #1 and Resident #2 care plans were not updated. The ADON stated that it was important for care plans to be accurate so staff are aware that it could happen again and of interventions and risks factors individualized to each resident. Interview on 07/19/2024 at 6:40 PM with the DON revealed that Resident #2 had manipulative behaviors sometimes instigated arguments with resident, yelled and cussed at staff and other residents. The DON stated that they tried to anticipate his needs and knew that he had to be approached a certain way. The DON stated that the family had snuck liquor into his room and there was a time where he had to have medication held because he showed signs of being intoxicated and they had found liquor bottles and vapes in his room. The DON stated that Resident #2 does not like another resident at the facility and they have to keep them separated from each other or facing different sides of the room so they have little interaction. Interview on 07/22/24 at 1:25 PM with DON revealed she expected resident comprehensive care plans to be person-centered. She stated she was not aware Resident #1's care plan did not include her unwitnessed fall with injury of hip fracture in February 2024. The DON stated she was unaware of Resident #2's care plan not being person centered and including his behaviors. She stated resident comprehensive care plans should be updated with acute changes and change of condition by the ADON. Review of facility's care plan policy titled Care Plans, Comprehensive Person-Centered, dated 2001 and revised December 2016, reflected comprehensive, person-centered care plans were to be developed and implemented for each resident and included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs . 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; d. Describe any specialized services to be provided as a result of PASARR recommendations; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Include the resident's stated goals upon admission and desired outcomes; f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire; g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; i. Build on the resident's strengths; j. Reflect the resident's expressed wishes regarding care and treatment goals; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions . 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview and record review, the facility failed to ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one (Residents #1) of six residents reviewed for pain management. 1. The facility failed to ensure Resident #1 was assessed, monitored and received effective pain management by LVN A after Resident #1 was found on the floor with indications of pain when mumbling and grumbling during transfer at time of unwitnessed fall on 02/24/24 at 12:17 AM. Resident #1 received no pain management from LVN A. 2. The facility failed to ensure Resident #1 received pain medication until after a 9 hour delay after the an unwitnessed fall. Resident #1 exhibited increasing signs of pain indicated by facial grimacing, moaning and holding her left hip. LVN B failed to follow Resident #1's prn physician order of administering Tylenol 500 mg before the 4 hours and failed to notify the physician of Resident #1's pain medication not being effective. 3. The facility failed to ensure effective pain management was provided to Resident #1 resulting in increased indicators of pain which resulted in 911 being called after Resident #1's POA intervention to contact Physician. Resident #1 was admitted to the hospital (19 hour delay since pain onset) for a left displaced hip fracture and had surgery to repair the fracture An Immediate Jeopardy (IJ) was identified on 07/17/24. The IJ Template was provided to the facility on [DATE] at 12:15 PM. While the IJ was removed on 07/19/24, 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 on pain management. These failures placed residents at risk of experiencing significant pain, discomfort and hospitalization . Findings include: Review of Resident #1's face sheet dated 07/16/24 reflected Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had diagnoses of traumatic brain injury (form of acquired brain injury occurs when a sudden trauma causes damage to the brain), hypertension (high blood pressure), unsteadiness on feet, cognitive communication deficit, anxiety disorder (persistent feelings of worry or fear) and depression disorder (episodes of persistently sad moods) and a BIMS score of 00 (severely impaired cognition). (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's comprehensive care plan last revised on 06/11/24 revealed resident had experienced multiple falls and included a fall on 02/24/2024 but did not indicate injury of hip fracture. Interventions included floor mats next to bed when resident was in bed, ensure her nonskid socks are on, and check frequently to make sure resident was not self-transferring, and to monitor pain during task. Review of Event Report for Resident #1 by LVN A with an event date of 02/24/2024 at 12:17 AM, dated recorded 02/24/2024 at 06:18 AM and closed date of 02/26/2024 at 1:38 PM by the DON reflected an unwitnessed fall in resident room. Resident seen lying on her right side on the floor in her room. Resident confused, pacing around in hallway & room. Resident re-directed & repositioned back to bed several times but prove abortive. CNA called [Charge Nurse] that resident is on the floor, resident seen lying on her right side on the floor close to the door. When asked, resident unable to explain, Resident mumbling & grumbling during transfer. Vital signs Blood pressure: 129/73, Pulse :68, Respirations:18, 02:96% [room air], T:97.4. No skin tear noted. Stat xray to bilateral hip ordered. Resident's POA, Supervisor & MD notified. Neuro checks initiated. Resident's pain was noted to be a 1 out of 10 (mild) and had painful and/or limited range of motion in her lower extremities. She was responsive to her name and to pain and was able to perceive her environment clearly and responded appropriately to stimuli. Review of Post Fall Observation report with an observation date of 02/24/2024 at 12:21 AM and completed dated of 02/24/2024 at 6:24 AM by LVN A reflected Resident #1 was previously in her bed and had an unwitnessed fall and was seen lying on her left side in her room. LVN A documented that Resident #1 had an agitated and confused mental status prior to the fall, and a pain level of 3 of 10 at 06:26 AM. Review of Resident #1's nurse's progress note dated 02/24/2024 at 1:48 AM by LVN A revealed resident had an unwitnessed fall and the Physician, supervisor, and resident's representative were notified and a STAT x-ray to both hips were ordered. Review of Resident #1's nurse's progress note dated 02/24/2024 at 10:11 AM by LVN B reflected 9am Resident has facial grimacing and has been holding her left hip. [Physician C] notified ordered [Tylenol] 500mg tablet one q 4hrs prn pain.[Tylenol] 500mg tab one given for pain inital [sp] dose given for pain for pain level of 5. Repositioned in bed with both legs in straight alignment using pillows to keep legs straight align ment.10am good results from pain med.(1) 1011am Phone call made to [X-ray Company N] and they said he will be here shortly. Review of Resident #1's nurse's progress note dated 02/24/2024 at 12:27 PM by LVN B revealed at 12:24 PM [x-ray company N] had arrived to x-ray resident's hips and resident was observed moaning and holding her left hip and was given a Tylenol 500 mg for a pain level noted as a 4 and was turned and repositioned with pillows. Review of Resident #1's nurse's progress note date 02/24/2024 at 7:21 PM by LVN B revealed Resident #1's family had visited and were told the x-ray results were not in yet and staff had called x-ray services and they stated it would be awhile until results were ready. LVN B documented that the POA wanted Physician C called to ask for an order to transfer Resident #1 to the hospital via ambulance to be evaluated by the emergency room doctor. LVN B documented that Physician C gave orders to send Resident #1 to the hospital and Resident #1 was being transported via ambulance at 5:00 PM and DON notified at 5:09 PM. (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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Physician Orders for February 2024 reflected a physician order with a start date of 02/24/2024 and end date of 02/28/2024 for APAP [Tylenol] 500 MG one tablet, every 4 hours for pain. Record review of February 2024 MAR for 02/01/2024-02/29/2024 revealed an order for a pain evaluation every shift, 6:00 AM- 6:00 PM (day shift) and 6:00 PM to 6:00 AM shift (night shift). Review of resident pain level on the night shift of 02/23/2024 showed entry, initialed by LVN A, that noted resident's pain was a 0. The following morning shift on 02/24/2024 initialed by LVN B recorded a pain of 5. Review of Resident #1's MAR for February 2024 revealed a physician order with a start date of 02/24/2024 and end date of 02/28/2024 for APAP [Tylenol] 500 MG one tablet, every 4 hours for pain with blank spaces for 02/24/2024. Review of Hospital EMS record dated 02/24/24 reflected EMS received a phone call on 02/24/24 at 5:02 PM from facility. Resident #1 was transported from facility to local hospital for a possible hip fracture. Patient was having right hip pain secondary to a fall she sustained at 0100 this morning. Nursing staff stated they called for transport due to the patient not getting better. Patient was transported supine and immobilized the right hip area. Patient also has a history of [traumatic brain injury] due to a fall and hitting her head on a marble coffee table as stated by family in the room .Patient complains of pain on the left side during any movement . Lower extremities-patient had pain on left side with shortening of the left leg The EMS record reflected Resident #1 had chief complaint of hip hurting for 16 hour duration. Review of Hospital paperwork for Physician documentation dated 02/24/24 from Emergency Doctor reflected Resident #1 diagnosis of fracture of unspecified part of neck of left femur bone (hip fracture). Resident #1 presented to ER with complaints of hip injury .coming into the emergency room with left hip pain after she had a fall at the nursing home patient denies any other injuries, she does have deformity on the left hip.X-ray shows a femoral neck fracture on the left side. Review of Hospital paperwork of Admitting History and Physical dated 02/24/24 reflected Resident #1 was a [AGE] year-old female nursing home resident with history of dementia, coronary artery disease, hypertension, type 2 diabetes and seizure disorder .She continued to have pain in left hip area after the fall at nursing home .Evaluation revealed left femoral neck (hip) fracture .It is relieved with oral hydrocodone . Pain with any movement of left hip .Plan.1. Left femoral neck fracture: Patient will be admitted to the hospital. IV morphine will be given as needed for pain control .orthopedic surgery was consulted. Plan to have surgical open reduction internal fixation tomorrow . Review of Hospital X-rays CR for pelvis and left hip with pain with traumas/injury dated 02/24/24 reflected Resident #1 had an acute left displaced subcapital femoral neck fracture (hip fracture). Review of Resident #1's X-ray by X-ray Company N of bilateral hips with pelvis dated 02/24/24 signed at 7:55 PM reflected an acute transverse fracture of the left of the neck femur (hip fracture). Review of Email dated 02/24/24 at 7:59 PM reflected DON and ADON were emailed to indicate a critical finding was flagged for patient [Resident #1], service date 02/24/24. Observation on 07/16/2024 at 9:40 AM of Resident #1 revealed she was asleep in bed on low position and with floor mats and interview with resident revealed she was confused, pleasant, and did not remember falling. (continued on next page)

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	675067	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/16/24 at 2:09 PM with resident's POA revealed on 02/24/2024 she was notified by the night nurse (LVN A) in the middle of the night that Resident #1 had a fall and was found on the floor with her blankets tangled around her legs and x-ray was ordered for Resident #1. She had another call later in the morning by LVN B about Resident #1 had been in bed all day and had a little discomfort and crying and was given Tylenol for pain and were awaiting x-ray to come. The POA and another family member visited Resident #1 on 02/24/24 in the late afternoon and resident was in bed with a pillow propped under her knee. POA said it seemed like the resident could not get comfortable because when she would make any movement with the left leg she would cry and grab it. She stated Resident #1 did not typically have pain and she was concerned that the fall had occurred in the middle of the night but there were still no x-ray results and resident was crying with any little movement and said it hurt. The POA stated she told the nurse (LVN B) that she was going to call 911 and have resident transported to ER and nurse said they needed to call the doctor to get an order and that the nurse would call. The POA checked a few minutes later and the nurse was helping a different resident and the POA and family member stated they would call 911 and nurse said no, she would do it immediately. The POA stated that she was frustrated that it seemed to take another 45 minutes before they had the call from Physician C to send resident to hospital via ambulance. The POA stated that the resident ended up having a fracture and had hip surgery. The POA stated she called the Administrator the following day and expressed her frustration about the delay in getting the resident to the hospital and x-ray results. The POA stated that the Administrator stated she knew and understood and had turned it in [to HHSC]. Interview on 07/16/2024 at 2:42 PM via phone with Physician C revealed he was notified in the middle of the night on 02/24/2024 that Resident #1 had a fall with some pain with movement and he ordered a STAT x-ray. He stated he thought he was called again later in the morning about the resident having some pain and he ordered Tylenol 500 mg every 4 hours as needed and asked about the status of the x-ray and was told they were waiting for x-ray to arrive. He stated he did not know Resident #1 was experiencing increasing pain until later into the evening when he was contacted by facility and informed that the family requested Resident #1 be sent to the emergency room (ER) due to her pain levels. He instructed that Resident #1 be sent to the hospital for an evaluation due to the level of pain resident had and the results of the x-ray were still pending. Physician C stated he reviewed the nurse's progress notes and did not know why Resident #1 received Tylenol 500 mg on 02/24/2024 at 9 am and then at 12:24 pm because it was too soon for another dose that if contacted he would have ordered a Tylenol #3 which is slightly stronger to manage the pain. Physician C stated that his expectation was if a resident's pain was not controlled then he would be called and he would either order stronger pain medication or send the resident to the hospital. Physician C stated that he expected the nurses to use their judgement and if a resident fell , and there was a suspicion of injury or the resident had uncontrolled pain, then they can send her to the ER themselves. He stated Resident #1 had injury of hip fracture. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/16/2024 at 3:12 PM via phone with LVN A revealed on 02/24/24 resident was up and pacing the halls that evening which was typical for her and she was put back to bed a number of times. LVN A stated the CNA alerted LVN A that Resident #1 had fallen and she observed the resident lying on right side on the floor in her room next to her bed. LVN A stated that she assessed Resident #1 and she didn't seem to be in much pain but only mumbled and grumbled during transfer back into bed. She states she notified the doctor and the POA and an x-ray was ordered STAT by physician due to resident having some pain. LVN A stated she did not remember giving any pain medication to Resident #1 on her shift. LVN A stated she noticed later into her shift that Resident #1 was having more pain and discomfort when moving her lower extremities. She stated she contacted x-ray company about the STAT x-ray by phone but could not recall when she called the STAT x-ray in. LVN A stated she notified LVN B at shift change of Resident #1 had a fall and x-ray ordered for Resident #1. She stated she was not in-serviced on pain management or x-ray services since incident. Interview on 07/17/2024 at 5:09 PM via phone with LVN B revealed she was familiar with Resident #1 and that she had falls in the past but never had a serious injury until February 2024. She stated Resident #1 typically walked up and down the halls and it was common for her to cry, ask for family members, to lash out and throw things, hit or kick. LVN B stated that Resident #1 was able to indicate that she had pain verbally and would point to the area or say hurt. LVN B stated that on 02/24/2024 during the night to day shift change, LVN A informed her that Resident #1 had experienced a fall around the middle of the night- the POA and physician had been contacted, and an order for a STAT X-ray had been ordered. LVN B stated that during her shift Resident #1 did not display her typical behavior, she was in bed, displayed signs of pain such as facial grimacing and holding her left leg which appeared slightly turned out and was painful to touch. LVN B stated she thought Resident #1 had broken her hip. LVN B stated that she called Physician C around 9:00 AM to ask for pain medication because the resident did not have any orders pain medication and he prescribed Tylenol 500 mg as needed every 4 hours for pain and asked if the x-ray results were in yet. LVN A stated she told him they were not in yet and she would call about the x-ray status. LVN B stated that she gave Resident #1 Tylenol 500 mg and called the x-ray company at 10:11 AM and they stated they would be there soon. LVN B stated she must have forgotten to document she gave the Tylenol to Resident #1 in the Medication Administration Record (MAR) because there was a lot going on and Resident #1 ended up going back to sleep but was restless. LVN B stated that she did her best to make Resident #1 as comfortable as possible while waiting for x-ray to arrive and repositioned resident with legs in straight alignment using pillows to keep the legs straight based on her nursing experience that if a resident has a broken hip then you want to keep the legs straight. LVN B stated that around 12:24 PM the x-ray arrived and resident was observed to be moaning and crying during the x-ray and she repositioned the resident with straight legs and gave her another Tylenol 500 mg. LVN B stated Resident #1 was restless and with any little movement, expressed pain verbally, said she was hurting, had facial grimacing, and was pointing and holding at both sides of her hip but mostly the left side. LVN B stated that around 4:00 PM on 02/24/2024 the POA arrived and was concerned about the resident. LVN B stated Resident #1 had facial grimacing, grabbed at both of her hips, cried with any movement and said she was in pain. She stated at the POA's request she contacted Physician C and received an order to transfer resident to the emergency room around 5:00 PM. She stated she was not in-serviced on pain management or x-ray services since incident. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/19/24 at 2:36 PM with CNA G revealed she worked the day shift on 02/24/24 when Resident #1 was grunting. She stated she overheard LVN A tell LVN B about Resident #1 having a fall on the night shift. She stated at breakfast Resident #1 did not want to get up and eat breakfast. She recalled during her shift Resident #1 was crying constantly and looked to be in pain by holding and gesturing to left side. She stated LVN B gave Resident #1 pain medication not sure what time sometime after breakfast. CNA G stated she used gait belt to transfer Resident #1 into wheelchair and put her back in bed with gait belt. She stated Resident #1 was showing signs of pain of moaning and crying along with holding and guarding her left side. She stated LVN B did not give her any instruction about transferring or positioning resident. She stated Resident #1 stayed in the bed for the rest of the shift after noticing Resident #1 was in pain with transfer. She stated sometime after lunch before supper Resident #1's family came and were upset the x-ray results were not in yet for Resident #1 asking for her to be sent to hospital due to her being in pain. She stated LVN B sent Resident #1 to the hospital. Interview on 07/16/2024 at 12:58 PM with the DON revealed if a resident falls they are assessed by a nurse for pain and injury and if a resident could not speak, the PAINAD (pain assessmnt scale) should be used. The DON stated she expected mobile STAT x-ray can take anywhere up to 4-6 hours to be completed. The DON stated that she expected staff to document any medication given in the MAR. She was not able to find documentation of pain medication given in the February 2024 MAR for Resident #1. Interview on 07/16/2024 at 1:26 PM with the Corporate Nurse, revealed her expectations for staff documentation of medication administration were the same as the DON mentioned and expected it to be documented in the MAR to show pain medication administered. Interview on 07/17/2024 at 10:56 AM with LVN F revealed she was familiar with Resident #1 and was not working on the day of her fall on 02/24/2024. LVN F stated Resident #1 did not typically display pain indicators before her fall on 02/24/2024 and she was able to point to or tell you where the pain was and cried if in pain. She stated she could not recall an in-service on pain management she received. Interview on 07/17/24 at 11:01 AM with LVN I revealed she had not received an in-service or training on x-ray services or pain management within the last year that she could recall. Interview on 07/17/24 at 11:12 AM with CNA H revealed Resident #1 yelled out when in pain after she sustained hip fracture but she did not work on 02/24/24. She stated Resident #1 grumbling or mumbling during movements was not normal it would tell me she was hurting and in pain. She states she would tell the nurse of any indicators of pain for residents immediately. Review of Email received from X-ray Company N dated 07/16/24 at 4:38 PM sent to ADON revealed the X-ray Company N notes indicated received phone call from [LVN A] at 4:01 AM who took the order. It was originally placed as routine. [LVN B] called at 10:21 AM and the order was changed to a STAT. [X-ray tech] called facility at 10:40 am and spoke to [LVN A] with ETA. [X-ray tech] arrived at 12:15 PM . (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews on 07/16/24 at 5:32 and 5:56 PM with ADON revealed Resident #1 was sent out via 911 by LVN B after LVN B notified Physician C and physician ordered Resident #1 to be sent out to hospital for further evaluation. She stated she expected stat x-ray results to be completed within 4 to 6 hours. She was not sure what time stat x-ray results had come to the facility and Resident #1 was sent to the hospital prior to receiving stat x-ray results. She stated she was not working on 02/24/24 and did not read her email to indicate Resident #1 had critical finding for her x-ray. She stated she was aware of Resident #1 being sent to the hospital and having a fracture on 02/25/24 when she was at work. Interview on 07/17/24 at 9:05 AM with DON revealed she expected charge nurse to document what time she contacted x-ray company to order stat x-ray and when she notified Physician C. She stated the stat x-ray order should have been put in the electronic record as a telephone order after getting the order from Physician C. She stated she was unable to find documentation of telephone physician order by LVN A. She stated LVN B should have documented the administration of the prn Tylenol order on 02/24/24 but stated at least it was in the progress notes when Resident #1 received Tylenol. She stated Resident #1 was sent out to the hospital on 02/24/24 at 5:09 PM and facility had not received the stat x-ray results. The DON stated Resident #1 should have been sent out to the hospital prior to 5 pm if Resident #1 was exhibiting increasing signs of pain as indicated by the progress notes. She stated LVN A should have reached out to the physician for a pain medication order and to give a report of Resident #1's pain to the physician. The DON stated a delay in pain management placed Resident #1 at risk for increased pain and suffering. She stated she did not review Resident #1's stat x-ray results until 02/25/24 and she did receive an email in the evening about a critical x-ray result but she did not review it until the next morning. She stated Resident #1's stat x-ray results were not received until after Resident #1 was sent to the hospital. She stated the facility had not in-serviced on pain management or x-ray services since 02/24/24. Interview on 07/19/2024 at 3:20 PM with ADON revealed Resident #1 did not usually have pain and when she did she would be able to say she is in pain by gesturing to area she was hurting. She stated Resident #1 would display pain indicators with facial grimaces, crying, or sweating. The ADON stated that if a resident is nonverbal then they would display signs of pain such as grimacing, breathing changes, guarding of the site, crying; and for residents with dementia the PAINAD scale should be used to assess pain. She stated based on reviewing Resident #1's progress notes on 02/24/24 by LVN A and LVN B there were indicators of pain displayed by Resident #1 including grumbling during transfer, grimacing, crying, moaning and holding onto her hip. Review of facility's in-service dated 10/21/23 to Nurses and CNA reflected Acute Condition Changes - Clinical Protocol policy was reviewed which included Nurse shall assess and document/report the following baseline information .c. Current level of pain, and any recent changes in pain level . It reflected LVN B attended in-service but LVN A did not attend in-service. Review of facility's policy titled Pain Assessment and Management, dated 2001 and revised March 2015, reflected to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Under general guidelines . 1. The pain management program is based on a facility-wide commitment to resident comfort. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of facility's in-service initiated for 07/17/24 reflected CNAs, nursing and nursing administration (ADON, Weekend RN Supervisor and DON) were in-serviced on pain management, nursing documentation about pain assessment, notification to physician when exhibit change of condition of pain onset, physician orders for pain medication and x-ray orders, and laboratory, diagnostic and radiology services On 07/19/24 between 10:55 AM and 6:51 PM revealed four (4) licensed vocational nurses were interviewed, from different shifts, on training and new system to ensure compliance for pain management. All nursing staff were able to verbalize understanding of how to assess for pain for residents with nonverbal indicators to use painad scale and give examples of pain indicators for nonverbal residents. Nursing was in-serviced on training regarding stat x-rays to be completed in timely manner and to follow up to get results in a timely manner. They were knowledgeable of expectation of physician's orders for x-rays that they needed to obtain x-ray orders and contact x-ray company to follow the physician x-ray orders. Nursing was knowledgeable on inputting physician orders for x-rays and to notify physician if there is a delay in stat x-ray services. Nursing stated if resident showed increasing signs of pain since unwitnessed fall and/or pain during movements they would send resident out to hospital for further evaluation. They would contact ADON, DON or weekend RN supervisor if having issues with x-ray services. Nursing aware of time for completion of stat x-rays to be with 4 to 6 hours and to follow up if results of stat x-ray have not been received. On 07/19/24 between 2:36 PM to 6:15 PM revealed four (4) CNAs were interviewed, from different shifts on training and notifying nurses of indicators of resident pain. All CNAs could give examples of verbal and nonverbal indicators of pain and would immediately notify charge nurse of any concerns with resident pain. If CNAs felt like nurse was not following up with resident about pain, then they would notify the ADON or DON. Review of Resident #2 and Resident #6's clinical record reflected no concerns with physician orders for pain medication and MAR documentation for pain management. Interview on 07/19/24 with ADON at 4:45 PM revealed LVN B is currently on leave and she will be in-serviced 1:1 about pain management and x-ray services timeliness. She stated she was responsible to ensure new nurses were in-serviced going forward prior to working the floor on pain management and x-ray services. She stated her and the DON have incorporate a tool of auditing residents sent to hospital and x-ray services to ensure timeliness of stat x-rays ordered. She stated they have not in-serviced LVN A yet and will be doing a 1:1 inservice with her a[TRUNCATED]

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on interview and record review the facility failed to provide radiology or other diagnostic services to meet the needs of its residents in a timely manner for one (Resident #1) of six residents reviewed for radiology services. 1. The facility failed to ensure that a stat x-ray was completed in a timely manner for Resident #1 on 02/24/24. 2. The facility failed to follow up to get Resident #1's stat x-ray results in a timely manner on 02/24/24. Resident #1 had an unwitnessed fall on 02/24/24 at 12:17 AM and sustained an injury. LVN A failed to ensure x-ray physician order was placed stat and not routine 12 hours after the unwitnessed fall, X-ray tech was at facility to complete stat x-ray for Resident #1. 17 hours after unwitnessed incident, Resident was sent to hospital for increasing pain and x-ray results had not been received. As a result, Resident #1 was admitted to the hospital (19 hour delay) since pain onset and unwitnessed fall for a left displaced hip fracture and had surgery to repair the fracture. An Immediate Jeopardy (IJ) was identified on 07/17/24. The IJ Template was provided to the facility on [DATE] at 12:15 PM. While the IJ was removed on 07/19/24, 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 on x-ray services. These failures could place resident at risk of results in delayed diagnosis, medical treatment, and hospitalization . Findings include: Review of Resident #1's face sheet dated 07/16/24 reflected Resident #1 was a [AGE] year-old female admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Review of Resident #1's Quarterly MDS dated [DATE] reflected Resident #1 had diagnoses of traumatic brain injury (form of acquired brain injury occurs when a sudden trauma causes damage to the brain), hypertension (high blood pressure), unsteadiness on feet, cognitive communication deficit, anxiety disorder (persistent feelings of worry or fear) and depression disorder (episodes of persistently sad moods) and a BIMS score of 00 (severely impaired cognition). Review of Resident #1's comprehensive care plan last revised on 06/11/24 revealed resident had experienced multiple falls included a fall on 02/24/2024 but did not indicate injury of hip fracture. Interventions included floor mats next to bed when resident was in bed, ensure her nonskid socks are on, and check frequently to make sure resident was not self-transferring, and to monitor pain during task. (continued on next page)

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	675067	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Event Report for Resident #1 by LVN A with an event date of 02/24/2024 at 12:17 AM, dated recorded 02/24/2024 at 06:18 AM and closed date of 02/26/2024 at 1:38 PM by the DON reflected an unwitnessed fall in resident room. Resident seen lying on her right side on the floor in her room. Resident confused, pacing around in hallway & room. Resident re-directed & repositioned back to bed several times but prove abortive. CNA called [Charge Nurse] that resident is on the floor, resident seen lying on her right side on the floor close to the door. When asked, resident unable to explain, Resident mumbling & grumbling during transfer. Vital signs Blood pressure: 129/73, Pulse :68, Respiratoins:18, 02:96% [room air], T:97.4. No skin tear noted. Stat xray to bilateral hip ordered. Resident's POA, Supervisor & MD notified. Neuro checks initiated. Resident's pain was noted to be a 1 out of 10 (mild) and had painful and/or limited range of motion in her lower extremities. She was responsive to her name and to pain and was able to perceive her environment clearly and responded appropriately to stimuli. Review of Post Fall Observation report with an observation date of 02/24/2024 at 12:21 AM and completed dated of 02/24/2024 at 6:24 AM by LVN A reflected Resident #1 was previously in her bed and had an unwitnessed fall and was seen lying on her left side in her room. LVN A documented that Resident #1 had an agitated and confused mental status prior to the fall, and a pain level of 3 of 10 at 06:26 AM. Review of Resident #1's nurse's progress note dated 02/24/2024 at 1:48 AM by LVN A revealed resident had an unwitnessed fall and the Physician, supervisor, and resident's representative were notified and a STAT x-ray to both hips were ordered. Review of Resident #1's nurse's progress note dated 02/24/2024 at 10:11 AM by LVN B reflected 9am Resident has facial grimacing and has been holding her left hip. [Physician C] notified ordered [Tylenol] 500mg tablet one q 4hrs prn pain.[Tylenol] 500mg tab one given for pain inital [sp] dose given for pain for pain level of 5. Repositioned in bed with both legs in straight alignment using pillows to keep legs straight align ment.10am good results from pain med.(1) 1011am Phone call made to [X-ray Company N] and they said he will be here shortly. Review of Resident #1's nurse's progress note dated 02/24/2024 at 12:27 PM by LVN B revealed at 12:24 PM [x-ray company N] had arrived to x-ray resident's hips and resident was observed moaning and holding her left hip and was given a Tylenol 500 mg for a pain level noted as a 4 and was turned and repositioned with pillows. Review of Resident #1's nurse's progress note date 02/24/2024 at 7:21 PM by LVN B revealed Resident #1's family had visited and were told the x-ray results were not in yet and staff had called x-ray services and they stated it would be awhile until results were ready. LVN B documented that the POA wanted Physician C called to ask for an order to transfer Resident #1 to the hospital via ambulance to be evaluated by the emergency room doctor. LVN B documented that Physician C gave orders to send Resident #1 to the hospital and Resident #1 was being transported via ambulance at 5:00 PM and DON notified at 5:09 PM. Review of Resident #1's Physician Orders for February 2024 reflected a physician order with a start date of 02/24/2024 and end date of 02/28/2024 for APAP [Tylenol] 500 MG one tablet, every 4 hours for pain. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Hospital EMS record dated 02/24/24 reflected EMS received a phone call on 02/24/24 at 5:02 PM from facility. Resident #1 was transported from facility to local hospital for a possible hip fracture. Patient was having right hip pain secondary to a fall she sustained at 0100 this morning. Nursing staff stated they called for transport due to the patient not getting better. Patient was transported supine and immobilized the right hip area. Patient also has a history of [traumatic brain injury] due to a fall and hitting her head on a marble coffee table as stated by family in the room .Patient complains of pain on the left side during any movement . Lower extremities-patient had pain on left side with shortening of the left leg The EMS record reflected Resident #1 had chief complaint of hip hurting for 16 hour duration. Review of Hospital paperwork for Physician documentation dated 02/24/24 from Emergency Doctor reflected Resident #1 diagnosis of fracture of unspecified part of neck of left femur. Resident #1 presented to ER with complaints of hip injury .coming into the emergency room with left hip pain after she had a fall at the nursing home patient denies any other injuries, she does have deformity on the left hip X-ray shows a femoral neck fracture on the left side. Review of Hospital paperwork of Admitting History and Physical dated 02/24/24 reflected Resident #1 was a [AGE] year-old female nursing home resident with history of dementia, coronary artery disease, hypertension, type 2 diabetes and seizure disorder .She continued to have pain in left hip area after the fall at nursing home .Evaluation revealed left femoral neck (hip) fracture .It is relieved with oral hydrocodone . Pain with any movement of left hip .Plan.1. Left femoral neck fracture: Patient will be admitted to the hospital. IV morphine will be given as needed for pain control .orthopedic surgery was consulted. Plan to have surgical open reduction internal fixation tomorrow . Review of Hospital X-rays CR for pelvis and left hip with pain with traumas/injury dated 02/24/24 reflected Resident #1 had an acute left displaced subcapital femoral neck fracture (hip). Review of Resident #1's X-ray by X-ray Company N of bilateral hips with pelvis dated 02/24/24 signed at 7:55 PM reflected an acute transverse fracture of the left of the neck femur (hip). Review of Email dated 02/24/24 at 7:59 PM reflected DON and ADON were emailed to indicate a critical finding (findings/results require immediate or urgent communication with the provider) was flagged for patient [Resident #1], service date 02/24/24. Observation on 07/16/2024 at 9:40 AM of Resident #1 revealed she was asleep in bed on low position and with floor mats and interview with resident revealed she was confused, pleasant, and did not remember falling. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/16/24 at 2:09 PM with resident's POA revealed on 02/24/2024 she was notified by the night nurse (LVN A) in the middle night that Resident #1 had a fall and was found on the floor with her blankets tangled around her legs and x-ray was ordered for Resident #1. She had another call later in the morning by LVN B about Resident #1 had been in bed all day and had a little discomfort and crying and was given Tylenol for pain and were awaiting x-ray to come. The POA and another family member visited Resident #1 on 02/24/24 in the late afternoon and resident was in bed with a pillow propped under her knee. POA seemed like the resident could not get comfortable because when she would make any movement with left leg she would cry and grab it. She stated Resident #1 did not typically have pain and she was concerned that the fall had occurred in the middle of the night but there were still no x-ray results and resident was crying with any little movement and said it hurt. The POA stated she told the nurse (LVN B) that she was going to call 911 and have resident transported to ER and nurse said they needed to call the doctor to get an order and that the nurse would call. The POA checked a few minutes later and the nurse was helping a different resident and the POA and family member stated they would call 911 and nurse said no, she would do it immediately. The POA stated that she was frustrated that it seemed to take another 45 minutes before they had the call from Physician C to send resident to hospital via ambulance. The POA stated that the resident ended up having a fracture and had hip surgery. The POA stated she called the Administrator the following day and expressed her frustration about the delay in getting the resident to the hospital and x-ray results. The POA stated that the Administrator stated she knew and understood and had turned it in [to HHSC]. Interview on 07/16/2024 at 2:42 PM via phone with Physician C revealed he was notified in the middle of the night on 02/24/2024 that Resident #1 had a fall with some pain with movement and he ordered a STAT x-ray. He stated he thought he was called again later in the morning about the resident having some pain and he ordered Tylenol 500 mg every 4 hours as needed and asked about the status of the x-ray and was told they were waiting for x-ray to arrive. He stated he did not know Resident #1 was experiencing increasing pain until later into the evening when he was contacted by facility and informed that the family requested Resident #1 be sent to the emergency room (ER) due to her pain levels. He instructed that Resident #1 be sent to the hospital for an evaluation due to the level of pain resident had and the results of the x-ray were still pending. Physician C stated he reviewed the nurse's progress notes and did not know why Resident #1 received Tylenol 500 mg on 02/24/2024 at 9 am and then at 12:24 pm because it was too soon for another dose that if contacted he would have ordered a Tylenol #3 which is slightly stronger to manage the pain. Physician C stated that his expectation was if a resident's pain was not controlled then he would be called and he would either order stronger pain medication or send the resident to the hospital. Physician C stated that he expected the nurses to use their judgement and if a resident fell , and there was a suspicion of injury or the resident had uncontrolled pain, then they can send her to the ER themselves. He stated Resident #1 had injury of hip fracture. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/16/2024 at 3:12 PM via phone with LVN A revealed on 02/24/24 resident was up and pacing the halls that evening which was typical for her and she was put back to bed a number of times. LVN A stated the CNA alerted LVN that Resident #1 had fallen and she observed the resident lying on right side on the floor in her room next to her bed. LVN A stated that she assessed Resident #1 and she didn't seem to be in much pain but only mumbled and grumbled during transfer back into bed. She states she notified the doctor and the POA and an x-ray was ordered STAT by physician due to resident having some pain. LVN A stated she did not remember giving any pain medication to Resident #1 on her shift. LVN A stated she noticed later into her shift that Resident #1 was having more pain and discomfort when moving her lower extremities. She stated she contacted x-ray company about the STAT x-ray by phone but could not recall when she called the STAT x-ray in. LVN A stated she notified LVN B at shift change of Resident #1 had a fall and x-ray ordered for Resident #1. She stated she was not in-serviced on pain management or x-ray services since incident. Interview on 07/17/2024 at 5:09 PM via phone with LVN B revealed she was familiar with Resident #1 and that she had falls in the past but never had a serious injury until February 2024. She stated Resident #1 typically walked up and down the halls and it was common for her to cry, ask for family members, to lash out and throw things, hit or kick. LVN B stated that Resident #1 was able to indicate that she had pain verbally and would point to the area or say hurt. LVN B stated that on 02/24/2024 during the night to day shift change, LVN A informed her that Resident #1 had experienced a fall around the middle of the night- the POA and physician had been contacted, and an order for a STAT X-ray had been ordered. LVN B stated that during her shift Resident #1 did not display her typical behavior, she was in bed, displayed signs of pain such as facial grimacing and holding her left leg which appeared slightly turned out and was painful to touch. LVN B stated she thought Resident #1 had broken her hip. LVN B stated that she called Physician C around 9:00 AM to ask for pain medication because the resident did not have any orders pain medication and he prescribed Tylenol 500 mg as needed every 4 hours for pain and asked if the x-ray results were in yet. LVN A stated she told him they were not in yet and she would call about the x-ray status. LVN B stated that she gave Resident #1 Tylenol 500 mg and called the x-ray company at 10:11 AM and they stated they would be there soon. LVN B stated she must have forgotten to document she gave the Tylenol to Resident #1 in the Medication Administration Record (MAR) because there was a lot going on and Resident #1 ended up going back to sleep but was restless. LVN B stated that she did her best to make Resident #1 as comfortable as possible while waiting for x-ray to arrive and repositioned resident with legs in straight alignment using pillows to keep the legs straight based on her nursing experience that if a resident has a broken hip then you want to keep the legs straight. LVN B stated that around 12:24 PM the x-ray arrived and resident was observed to be moaning and crying during the x-ray and she repositioned the resident with straight legs and gave her another Tylenol 500 mg. LVN B stated Resident #1 was restless and with any little movement, expressed pain verbally, said she was hurting, had facial grimacing, and was pointing and holding at both sides of her hip but mostly the left side. LVN B stated that around 4:00 PM on 02/24/2024 the POA arrived and was concerned about the resident. LVN B stated Resident #1 had facial grimacing, grabbed at both of her hips, cried with any movement and said she was in pain. She stated at the POA's request she contacted Physician C and received an order to transfer resident to the emergency room around 5:00 PM. She stated she was not in-serviced on pain management or x-ray services since incident. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/19/24 at 2:36 PM with CNA G revealed she worked the day shift on 02/24/24 when Resident #1 was grunting. She stated she overheard LVN A tell LVN B about Resident #1 having a fall on the night shift. She stated at breakfast Resident #1 did not want to get up and eat breakfast. She recalled during her shift Resident #1 was crying constantly and looked to be in pain by holding and gesturing to left side. She stated LVN B gave Resident #1 pain medication not sure what time sometime after breakfast. CNA G stated she used gait belt to transfer Resident #1 into wheelchair and put her back in bed with gait belt. She stated Resident #1 was showing signs of pain of moaning and crying along with holding and guarding her left side. She stated LVN B did not give her any instruction about transferring or positioning resident. She stated Resident #1 stayed in the bed for the rest of the shift after noticing Resident #1 was in pain with transfer. She stated sometime after lunch before supper Resident #1's family came and were upset the x-ray results were not in yet for Resident #1 asking for her to be sent to hospital due to her being in pain. She stated LVN B sent Resident #1 to the hospital. Interview on 07/16/2024 at 12:58 PM with the DON revealed if a resident falls they are assessed by a nurse for pain and injury and if a resident could not speak, the PAINAD should be used. The DON stated she expected mobile STAT x-ray can take anywhere up to 4-6 hours to be completed. The DON stated charge nurse was responsible for calling X-ray company N by phone after obtaining a physician order for x-ray orders including stat x-ray orders. Interview on 07/17/2024 at 10:56 AM with LVN F revealed she could not recall an in-service on pain management she received and was unaware of any in-service for X-ray services Interview on 07/17/24 at 11:01 AM with LVN I revealed she had not received an in-service or training on x-ray services or pain management within the last year that she could recall. Review of Email received from X-ray Company N dated 07/16/24 at 4:38 PM sent to ADON revealed the X-ray Company N notes indicated received phone call from [LVN A] at 4:01 AM who took the order. It was originally placed as routine. [LVN B] called at 10:21 AM and the order was changed to a STAT. [X-ray tech] called facility at 10:40 am and spoke to [LVN A] with ETA. [X-ray tech] arrived at 12:15 PM . Interviews on 07/16/24 at 5:32 and 5:56 PM with ADON revealed Resident #1 was sent out via 911 by LVN B after LVN B notified Physician C and physician ordered Resident #1 to be sent out to hospital for further evaluation. She stated she expected stat x-ray results to be completed within 4 to 6 hours. She stated X-ray company N reported according to their records Resident #1's x-ray was called in as routine at 4:01 by LVN A on 02/24/24 but was changed to stat by LVN B when she reached out to them. She was not sure what time stat x-ray results had come to the facility and Resident #1 was sent to the hospital prior to receiving x-ray results. She stated she was not working on 02/24/24 and did not read her email to indicate Resident #1 had critical finding for her x-ray. She stated she was aware of Resident #1 being sent to the hospital and having a fracture on 02/25/24 when she was at work. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 07/17/24 at 9:05 AM with DON revealed she expected charge nurse to document what time she contacted x-ray company to order stat x-ray and when she notified Physician C. She stated the stat x-ray order should have been put in the electronic record as a telephone order after getting the order from Physician C. She stated she was unable to find documentation of telephone physician order by LVN A. She stated LVN A should have documented and inputted x-ray order into the electronic record as a physician telephone order. She stated Resident #1 was sent out to the hospital on 02/24/24 at 5:09 PM and facility had not received the stat x-ray results. The DON stated Resident #1 should have been sent out to the hospital prior to 5 pm if Resident #1 was exhibiting increasing signs of pain and x-ray results had not been received as indicated by the progress notes. The DON stated a delay in receiving stat x-ray results could place Resident #1 at risk for increased pain and suffering. She stated she did not review Resident #1's stat x-ray results until 02/25/24 and she did receive an email in the evening about a critical x-ray result but she did not review it until the next morning. She stated Resident #1's stat x-ray results were not received until after Resident #1 was sent to the hospital. She stated the facility had not in-serviced on pain management or x-ray services since 02/24/24. Facility was unable to provide any in-service on X-ray services per DON on 07/16/24. Review of X-ray Company N's Contract with Facility effective 12/01/19 reflected C. Provider shall perform the service required hereunder in accordance with: I. All applicable federal, state, and local laws, rules and regulations. II. All applicable standards of all relevant accrediting organizations, and III. All applicable policies, rules and regulations. The facility did not have a policy for X-ray services per DON on 07/16/24. An Immediate Jeopardy was identified on 07/17/24. The Administrator and the DON were notified on 07/17/24 at 12:15 PM of the Immediate Jeopardy. IJ template provided at this time and plan of removal was requested. The facility's plan of removal was accepted on 07/18/24 at 3:49 PM. The accepted plan of removal for the Immediate Jeopardy included the following: Problem: Radiology (F776) The facility failed to ensure an x-ray was completed in a timely manner for a resident who sustained an injury/pain from a fall. The facility failed to follow up to get the results for a stat x-ray for a resident who sustained injury/pain from a fall in a timely manner. The facility failed to follow their policy for x-rays with residents who sustain an injury/pain with a fall. Plan: 11. [Physician C], Medical Director has been notified of the Immediate Jeopardy by the Administrator on 07/17/2024. QAPI was conducted with the medical director. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/19/24 between 10:55 AM and 6:51 PM revealed four (4) licensed vocational nurses were interviewed, from different shifts, on training and new system to ensure compliance for pain management. All nursing staff were able to verbalize understanding of how to assess for pain for residents with nonverbal indicators to use painad scale and give examples of pain indicators for nonverbal residents. Nursing was in-serviced on training regarding stat x-rays to be completed in timely manner and to follow up to get results in a timely manner. They were knowledgeable of expectation of physician's orders for x-rays that they needed to obtain x-ray orders and contact x-ray company to follow the physician x-ray orders. Nursing were knowledgeable on inputting physician orders for x-rays and to notify physician if there is a delay in stat x-ray services. Nursing stated if resident showed increasing signs of pain since unwitnessed fall and/or pain during movements they would send resident out to hospital for further evaluation. They would contact ADON, DON or weekend RN supervisor if having issues with x-ray services. Nursing aware of time for completion of stat x-rays to be with 4 to 6 hours and to follow up if results of stat x-ray have not been received. Interview on 07/19/24 with ADON at 4:45 PM revealed LVN B is currently on leave and she will be in-serviced 1:1 about pain management and x-ray services timeliness. She stated she was responsible to ensure new nurses were in-serviced going forward prior to working the floor on pain management and x-ray services. She stated her and the DON have incorporate a tool of auditing residents sent to hospital and x-ray services to ensure timeliness of stat x-rays ordered. She stated they have not in-serviced LVN A yet and will be doing a 1:1 inservice with her about pain management, documentation and x-ray services timeliness. She stated all current staff have been in-serviced and she will be working this weekend to ensure all nursing are in-serviced. She stated at morning meeting they will discuss any residents sent to the hospital, any concerns with pain management and x-ray services. She stated RN weekend supervisor will be overseeing on the weekends to ensure pain management and x-ray services are addressed. She stated the DON is out today due to personal leave. She stated her and the DON will be notified of any critical x-ray lab results and will look at them immediately then they will contact the charge nurse to follow up to ensure nursing is addressing resident needs. On 07/19/24 at 7:03 PM, the Administrator was informed the IJ was removed. However, the facility remained out of compliance at a scope of pattern that is not immediate jeopardy and severity level of potential for more than minimal harm. The facility needs to ensure in-service training and evaluate the effectiveness of the corrective systems for diagnostic services. 49427

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675067	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gainesville Convalescent Center	1900 O'Neal St Gainesville, TX 76240

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 control program designed to prevent the development and transmission of infection for 1 resident of 8 residents (Resident #5) observed for infection control. The facility failed to ensure CNA G performed hand hygiene and changed gloves during incontinent care for Resident #5. This failure could place residents at risk for infection and cross contamination of pathogens and illness. Findings include: Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected Resident #5 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included hemiplegia (paralysis that affects only one side of the body), muscle wasting, and cerebral infarction (a condition that occurs when blood flow to the brain is disrupted, causing tissue death in the brain). Resident #5's BIMS score of 10, which indicated Resident #5's cognition was moderately impaired. The MDS assessment indicated Resident #5 required maximal assistance with toileting and personal hygiene. The MDS assessment indicated Resident #5 was always incontinent of bowel and bladder. Observation on 07/16/24 at 10:38 AM revealed CNA G entered Resident #5's room to provide incontinence care. CNA G washed her hands and donned (put on) gloves, she unfastened Resident #5's brief, she cleaned the front pubic area with peri wipes. She then assisted resident on his side. She wiped the resident's buttock area with peri-wipes. CNA G then removed the soiled brief and with soiled gloves, placed the clean brief under the resident. CNA G removed and discarded the dirty gloves, she donned clean gloves without hand hygiene. She fastened the brief and covered resident. Once finished, she removes and discarded gloves, she washed hands and left the room. In an interview on 07/16/24 at 10:50 AM, CNA G stated she supposed to change her gloves and perform hand hygiene when she went from dirty to clean and acknowledged she did not do that. CNA G stated she should sanitize her hands between change of gloves. CNA G stated failing to provide proper care exposed the resident to infections. In an interview on 07/16/24 at 2:56 PM, the DON stated she expected the staff to remove their gloves and sanitize their hands when going from dirty to clean. She stated the staff should have sanitized hands between change of gloves. She stated no doing so would place resident at risk of cross contamination. Record review of the facility's policy, Hand Washing/Hand Hygiene , revised August 2015, reflected, . Hand hygiene the primary means to prevent the spread of infections. 7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap and water for the following situations: . m. After removing gloves.