STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675096	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Nursing and Rehabilitation of Hillsboro	1725 Old Brandon Rd Hillsboro, TX 76645

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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on interview, and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse/neglect and investigate such allegations for 1 (Resident # 1) of 6, residents reviewed for accidents and supervision. The facility failed to investigate a serious injury that occurred when Resident # 1 sustained a wrist fracture and other injuries CNA A left her unsupervised and she fell out the bed on 4/14/2024. This failure resulted in an identification of an (IJ) Immediate Jeopardy on 4/18/2024 at 6:07pm. The IJ Immediate Jeopardy template was provided to the ADM on 4/18/2024 at 6:07pm. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:26pm, the facility remained out of compliance at a scope of isolated and severity level of actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting. The failure could place residents at risk of accidents and harm. Findings included: Record review of Resident #1's face sheet dated 1/9/2024 reflected, Resident #1 is a [AGE] year-old female who was admitted to the facility on [DATE]. The face sheet reflected Resident #1 had the following diagnoses Other acute osteomyelitis (bone inflammation that can result in pelvis trauma), left femur, Muscle wasting and atrophy (wasting, thinning or loss of muscle tissue), not elsewhere classified, right upper arm, Muscle wasting and atrophy (muscle that lose their nerve supply), not elsewhere classified, left upper arm, Chronic pain syndrome (other symptoms beyond pain alone), Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), Functional quadriplegia(Complete Immobility due to sever disability or frailty from another medical condition without injury to the spinal cord). Record review of Resident's #1 admission MDS dated [DATE] BIMS score 15 cognitive intact GG functional section of MDS reflect the resident required substantial /maximal assistance with roll to left or right side. Record review of Resident #1 care plan dated 1/18/2024 reflected Resident # 1 required total staff performs /provides total assistance for all ADL's. The care plan reflected the following interventions: Keep call light within reach and encourage use for assistance. Respond promptly to all request for assistance. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident # 1 required a bed with side rails on both sides. Record review of physician order dated 3/24/2024 for Resident # 1 reflected Resident #1 required a 2x person assist and hoyer for transfers, mobility, bathing, and a 2x person assist with toileting. During an interview on 4/18/2024 at 11:17 a.m. a FM revealed Resident #1 called her last night 4/17/2024 and stated she fell out the bed on Sunday night 4/14/2024. The FM stated they did not make sure that she was in the center of the bed, she was on the edge and fell out the bed. The FM stated Resident #1 sustained a hairline fracture to her right wrist, she stated she also had a scar on her leg from where she fell and that he was swollen on the right side. The FM stated Resident # 1 was in a lot of pain because usually she did not cry but stated she was crying because of the pain from her injuries. During an interview on 4/18/2024 at 11:46 a.m. Resident #1 revealed on Sunday 4/14/2024 CNA A repositioned her on her left side and pulled her all the way to the edge of the bed and left the room. Resident # 1 stated when she realized she was falling she yelled out help- help. Resident # 1 stated there was another bedside table in the room and when she fell her face hit the table and then the floor, stated her leg also hit the table. Resident #1 stated she tried to brace her fall by putting her hand out and fractured her wrist. Resident #1 stated she was still in pain today and the facility were giving her medication to help with the pain. During an interview on 4/18/2024 at 4:00 p.m. the DON, revealed she was advised of the fall the next day on 4/15/2024. The DON stated nursing staff reported Resident # 1 was turned on left side to have a bowel movement and stated she fell out the bed. She stated Resident # 1 liked to be turned on her side when having a bowel movement. The DON stated the staff were able to look at the resident physician order report to see what their care needs are and to see if they are a one person or two persons assist. During an interview on 4/18/2024 at 4:20 p.m. the Admin. revealed she spoke with Resident #1 after the incident and stated Resident #1 stated the staff positioned her differently in the bed and she fell . She stated this was not reported to HHSC because she did not believe that it was intentional. The Admin. stated after she spoke with Resident # 1 that was the extent of her investigation. The Admin. stated she expected staff to position Resident #1 in the center of the bed while on her side and ensure that she was in a safe position before leaving the room. Record review of facility abuse prevention program dated November 2010 which reflected the following: Our residents have the right to be free from abuse and neglect. Our facility is committed to protecting our residents from abuse by anyone included but not necessarily limited to facility staff. Timely and thorough investigation of all reports and allegations of abuse. An (IJ) Immediate Jeopardy was identified on 4/18/2024 at 6:07pm., due to the above failures. The ADM was notified on 4/18/2023. The ADM was provided with the (IJ) Immediate Jeopardy template on 4/18/2023 at 6:07pm, and a Plan of Removal (POR) was requested. The Plan of removal accepted on 4/19/2024 at 1:26 p.m. and indicated the following: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan of Removal Date Initiated: 4/18/2024 and accepted on 4/19/2024. Residents #1 was assessed by DON and support was provided as accepted. Resident was informed that she would not be left alone during care. Resident was reminded that call light is available if she is concerned about safety. The physician was notified of the deficiencies cited on 4/18/2024. There were no new orders obtained. The affected resident's responsible party was notified by DON of the cited deficiencies and the plan of removal. CNA A was immediately suspended by DON and Administrator on 4/18/2024. CNA A will be terminated due to not following policy and procedures. On 4/18/2024 the DON (director of nursing) and Administrator interviewed all residents in the facility to determine if any other residents needed any assistive devices or had any concerns regarding staff not supervising during care. There were no concerns identified. The interviews were completed before midnight on 4/18/2024. Ad-Hoc (for this situation) QAPI meeting was held on 4/18/2024, with the Medical Director, NHA (Nursing Home Administrator), COO (Chief Operating Officer) and DON to review the cited deficiencies, policy and procedure, and the plan for removal of immediacy. On 4/18/2024 the COO completed 1:1 in-service on Abuse, Neglect and Incident and Accident Reporting with Administrator, DON, and ADON. The in-service also reviewed the importance of providing adequate supervision to residents during care. Starting on 4/18/24, the facility leadership (Administrator, DON, and ADON) will complete education with nursing staff on incidents and accidents and supervision. The leadership team also in serviced on reporting any incidents and accidents immediately to ensure that each resident receives the services consistent with the professional standards of practice. DON/designee reviewed the resident profiles to include the resident care plan. In servicing from DON and/or designee with direct care staff on how to access profiles in the Point of Care system. The in-services were consistent with nursing staff to be able to identify the type of care each resident needs for ADLs. The training was initiated on 4/18/24 and will be completed on 4/18/24. Nursing staff will give a return demonstration on how to pull profiles in the EMR and Point of Care system. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. Staff will not be allowed to work until they receive training. The policy pertaining to Incident, Accidents and supervision were reviewed on 4/18/24 by the DON, NHA (Nursing Home Administrator) and Medical Director. Current policy was reviewed with staff to ensure compliance. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting on 4/18/24, IDT (Interdisciplinary team), including Administrator, DON, ADON, Activity Director, MDS Coordinator, HR, BOM) will meet with all residents daily Monday to Friday, and Manager on Duty Saturday and Sunday to determine if any residents have any concerns on supervision during care or if any resident had an incident or accident that was not reported. Any concerns identified will be immediately brought to Administrator for further action, if necessary. All incidents and accidents will be documented in the electronic medical record. On 4/18/24 the COO will start reviewing any incidents or accidents to ensure complete investigation/reporting weekly for four (4) weeks followed by monthly reviews after. The DON/designee will monitor compliance by completing an audit of ten (10) residents per week for four (4) weeks. This was initiated on 4/18/24. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance. The Administrator will be responsible for ensuring this plan is completed on 4/18/24. The COO will provide oversight of DON and Administrators to ensure that the items on the plan of removal are reviewed and completed. Monitoring of POR on 4/19/2024 included the following: During an observation and interview on 4/19/2024 at 11:20 a.m. Resident #1 was in her room. She stated her mother had just left from visiting with her. She stated she still had pain in her back and wrist. She stated her doctor changed her PRN pain medications to every 12 hours. She stated it does not take staff a long time to answer her call light. She stated CNA J is especially fast. She stated she is not complaining, just mad that the Aide walked out and left her on her side without returning. During an interview on 4/19/2024 at 11:45 a.m. LVN C revealed they were in-serviced over the following at the Nursing Station: Abuse Prevention Program, Incident and Accident Reporting If you suspect or witness anything, inform the ADM and DON. She understands the protocol as she has been a nurse for over [AGE] years. You must make sure the safety of the resident is the main thing and you do whatever is necessary to protect them and keep them safe. If she needed further guidance, she would refer to her DON. During an interview on 4/19/2024 at 12:05 p.m. CNA D provided the following information: Abuse Prevention Program, Incident and Accident Reporting She had been a CNA for [AGE] years and she knows every time someone says they fell , she sees them on the floor, or if report they have been neglected, you are supposed to report it immediately to the Nurse, the DON, and the ADM (ANE Coordinator). She said she had never had to report any abuse or neglect other than a fall. She did not learn anything new, it was more of a refresher. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/19/2024 at 12: 25 p.m. CNA F. She provided the following information: Abuse Prevention Program, Incident and Accident Reporting They were told the signs of abuse and neglect, what to look for and who to report it to. They were told how to protect the resident until it is reported, and they are assessed. She did not learn anything new. It was more of a re-education as she had been in this field since 1999. It was the same information that she remembers. She stated she took away that abuse can also be between two residents, and you must remember what may seem minor to you, the resident can be affected negatively. During an interview on 4/19/2024 at 12:40 p.m. CNA E indicated he was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting He stated they gave everyone their own copy of each in-service. He stated they went over who to contact and what to do if it was an actual incident. He stated he knows any form of abuse and neglect needs to be reported. They have the signs of abuse and neglect posted on the wall by the time clocks and at the beginning of the 200 halls. He stated he did not learn anything new; it was more of a re-education. He stated he oversees the CNAs and conduct in-services with them. During an interview on 4/19/2024 at 12:55 p.m. LVN T. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if you see anything, you must report it to the ADM. You must chart it and fill out an event report. If you see any signs of abuse or neglect you should intervene if you witness it. She learned that locking a resident's wheelchair could be a form of abuse if they are mobile and they cannot unlock the wheelchair themselves. During an interview on 4/19/2024 at 1:20 p.m. CNA K. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if there is a sign of abuse or neglect you must contact the ADM. If you cannot get a hold of her in 10-15 minutes, you must contact the DON because they must report within 2 hours. She stated if you see something you must say something. She stated she has been working in facilities for over 5 years and did not learn anything new. She stated it was more of a reminder. During an interview on 4/19/2024 at 1:40 p.m. the DON provided the following information: Ad Hoc QAPI Meeting She stated they discussed the two Tags and discussed the resident of concern with the PCP. She stated they asked if he wanted anything changed to the policy, and he stated there was nothing at this time. She stated they informed him the CNA was suspended, pending termination. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Safe Surveys She stated herself, the MDS Coordinator and the ADON completed the Safe Surveys with each resident. She stated there were no concerns regarding abuse or neglect. She stated one female resident mentioned the Aides talk a lot. She stated one male resident said the Aide of Concern is a little gruff in speaking. She stated to eradicate this, the Aide is being terminated. She stated she will be doing more monitoring over the weekends on the halls and asking random residents about their care. Abuse Prevention Program, Incident and Accident Reporting She stated they went over all parts of the policy and the protection of residents. She stated they went over who to report it to and although they tell the nurse, they must still report it to the DON and the ADM themselves. She provided them a list of signs and symptoms and how the resident may react to being abused. She gave them examples of depression to know what to watch for with a resident. She stated it is not always verbal or physical, but it could be mental abuse, misappropriation, etc. During an interview on 4/19/2024 at 2:00 p.m. the Admin. provided the following information: Ad Hoc QAPI Meeting She stated they went over interviewing all residents for supervision related to incidents and accidents. She stated they discussed in-servicing all staff on Abuse and Neglect, Reporting, Incidents and Accidents. She stated staff not present would be called to provide education over the phone. She stated the IDT team reviewed all residents for abuse, and neglect to include supervision. She stated they discussed policy of ANE, Reporting, Incidents and Accidents. She stated no changes have been made and no new policies were created. She stated they reviewed the Plan of Removal with all attendees. She stated the COO in-serviced her, the DON and the ADON. She stated this morning, the Resident of Concern wanted to be left alone during her bowel movement and they had to re-educate her that it was not safe to do so. She stated the Resident was fine with the decision due to her safety. She stated due to taking a lot of pain medications, it causes the Resident to become constipated. She stated laying on her side, helps it to release. Safe Surveys She stated they completed Safe Survey Audits and spoke with every Resident at the facility. She stated only 2 mentioned that they did not care for the Aide Resident # 3 and Resident #4 stated due to the way she talks. She stated they were never harmed; they just did not care for her demeanor. She stated due to their feedback along with the incident with Resident # 1, they are moving forward with termination. She stated she is currently suspended, and her termination has been approved and will occur this afternoon via phone. Record review of in-service dated 4/18/2024 on Resident Rights completed by 38 staff. Record review of in-service dated 4/18/2024 on Positioning and Re-positioning residents in bed completed by 12 CNA and nursing staff. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress note dated 4/15/2024 regarding assessment of Resident # 1's hand/wrist, right leg and ankle. On 4/19/2023 at 1:29 p.m., the ADM was informed the (IJ) Immediate Jeopardy was removed. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:29 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 44526 Based on interview, and record review the facility failed to ensure all alleged violations were reported to HHSC for 1 (Resident # 1) of 6, residents reviewed for accidents and supervision. The facility failed to report to HHSC a serious injury that occurred. The facility failed to investigate a serious injury that occurred when Resident # 1 sustained a wrist fracture and other injuries CNA A left her unsupervised and she fell out the bed on 4/14/2024. The failure could place residents at risk of accidents and harm. Findings included: Record review of Resident #1's face sheet dated 1/9/2024 reflected, Resident #1 is a [AGE] year-old female who was admitted to the facility on [DATE]. The face sheet reflected Resident #1 had the following diagnoses Other acute osteomyelitis (bone inflammation that can result in pelvis trauma), left femur, Muscle wasting and atrophy (wasting, thinning or loss of muscle tissue), not elsewhere classified, right upper arm, Muscle wasting and atrophy (muscle that lose their nerve supply), not elsewhere classified, left upper arm, Chronic pain syndrome (other symptoms beyond pain alone), Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), Functional quadriplegia(Complete Immobility due to sever disability or frailty from another medical condition without injury to the spinal cord). Record review of Resident's #1 admission MDS dated [DATE] BIMS score 15 cognitive intact GG functional section of MDS reflect the resident required substantial /maximal assistance with roll to left or right side. Record review of Resident #1 care plan dated 1/18/2024 reflected Resident # 1 required total staff performs /provides total assistance for all ADL's. The care plan reflected the following interventions: Keep call light within reach and encourage use for assistance. Respond promptly to all request for assistance. Resident # 1 required a bed with side rails on both sides. Record review of physician order dated 3/24/2024 for Resident # 1 reflected Resident #1 required a 2x person assist and hoyer for transfers, mobility, bathing, and a 2x person assist with toileting. During an interview on 4/18/2024 at 11:17 a.m. a FM revealed Resident #1 called her last night 4/17/2024 and stated she fell out the bed on Sunday night 4/14/2024. The FM stated they did not make sure that she was in the center of the bed, she was on the edge and fell out the bed. The FM stated Resident #1 sustained a hairline fracture to her right wrist, she stated she also had a scar on her leg from where she fell and that he was swollen on the right side. The FM stated Resident # 1 was in a lot of pain because usually she did not cry but stated she was crying because of the pain from her injuries. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/18/2024 at 11:46 a.m. Resident #1 revealed on Sunday 4/14/2024 CNA A repositioned her on her left side and pulled her all the way to the edge of the bed and left the room. Resident # 1 stated when she realized she was falling she yelled out help- help. Resident # 1 stated there was another bedside table in the room and when she fell her face hit the table and then the floor, stated her leg also hit the table. Resident #1 stated she tried to brace her fall by putting her hand out and fractured her wrist. Resident #1 stated she was still in pain today and the facility were giving her medication to help with the pain. During an interview on 4/18/2024 at 4:00 p.m. the DON, revealed she was advised of the fall the next day on 4/15/2024. The DON stated nursing staff reported Resident # 1 was turned on left side to have a bowel movement and stated she fell out the bed. She stated Resident # 1 liked to be turned on her side when having a bowel movement. The DON stated the staff were able to look at the resident physician order report to see what their care needs are and to see if they are a one person or two persons assist. During an interview on 4/18/2024 at 4:20 p.m. the Admin. revealed she spoke with Resident #1 after the incident and stated Resident #1 stated the staff positioned her differently in the bed and she fell . She stated this was not reported to HHSC because she did not believe that it was intentional. The Admin. stated after she spoke with Resident # 1 that was the extent of her investigation. The Admin. stated she expected staff to position Resident #1 in the center of the bed while on her side and ensure that she was in a safe position before leaving the room. Record review of facility abuse prevention program dated November 2010 which reflected the following: Our residents have the right to be free from abuse and neglect. Our facility is committed to protecting our residents from abuse by anyone included but not necessarily limited to facility staff. Timely and thorough investigation of all reports and allegations of abuse.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on interview, and record review the facility failed to thoroughly investigate the incident of how Resident #1 was left unsupervised and fell from the bed. There was no evidence to show the incident had been investigated at all. The facility failed to investigate a serious injury that occurred when Resident # 1 sustained a wrist fracture and other injuries CNA A left her unsupervised and she fell out the bed on 4/14/2024. This failure resulted in an identification of an (IJ) Immediate Jeopardy on 4/18/2024 at 6:07pm. The IJ Immediate Jeopardy template was provided to the ADM on 4/18/2024 at 6:07pm. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:26pm, the facility remained out of compliance at a scope of isolated and severity level of actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting. The failure could place residents at risk of accidents and harm. Findings included: Record review of Resident #1's face sheet dated 1/9/2024 reflected, Resident #1 is a [AGE] year-old female who was admitted to the facility on [DATE]. The face sheet reflected Resident #1 had the following diagnoses Other acute osteomyelitis (bone inflammation that can result in pelvis trauma), left femur, Muscle wasting and atrophy (wasting, thinning or loss of muscle tissue), not elsewhere classified, right upper arm, Muscle wasting and atrophy (muscle that lose their nerve supply), not elsewhere classified, left upper arm, Chronic pain syndrome (other symptoms beyond pain alone), Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), Functional quadriplegia(Complete Immobility due to sever disability or frailty from another medical condition without injury to the spinal cord). Record review of Resident's #1 admission MDS dated [DATE] BIMS score 15 cognitive intact GG functional section of MDS reflect the resident required substantial /maximal assistance with roll to left or right side. Record review of Resident #1 care plan dated 1/18/2024 reflected Resident # 1 required total staff performs /provides total assistance for all ADL's. The care plan reflected the following interventions: Keep call light within reach and encourage use for assistance. Respond promptly to all request for assistance. Resident # 1 required a bed with side rails on both sides. Record review of physician order dated 3/24/2024 for Resident # 1 reflected Resident #1 required a 2x person assist and hoyer for transfers, mobility, bathing, and a 2x person assist with toileting. (continued on next page)

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	675096	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Nursing and Rehabilitation of Hillsboro	1725 Old Brandon Rd Hillsboro, TX 76645

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/18/2024 at 11:17 a.m. a FM revealed Resident #1 called her last night 4/17/2024 and stated she fell out the bed on Sunday night 4/14/2024. The FM stated they did not make sure that she was in the center of the bed, she was on the edge and fell out the bed. The FM stated Resident #1 sustained a hairline fracture to her right wrist, she stated she also had a scar on her leg from where she fell and that he was swollen on the right side. The FM stated Resident # 1 was in a lot of pain because usually she did not cry but stated she was crying because of the pain from her injuries. During an interview on 4/18/2024 at 11:46 a.m. Resident #1 revealed on Sunday 4/14/2024 CNA A repositioned her on her left side and pulled her all the way to the edge of the bed and left the room. Resident # 1 stated when she realized she was falling she yelled out help- help. Resident # 1 stated there was another bedside table in the room and when she fell her face hit the table and then the floor, stated her leg also hit the table. Resident #1 stated she tried to brace her fall by putting her hand out and fractured her wrist. Resident #1 stated she was still in pain today and the facility were giving her medication to help with the pain. During an interview on 4/18/2024 at 4:00 p.m. the DON, revealed she was advised of the fall the next day on 4/15/2024. The DON stated nursing staff reported Resident # 1 was turned on left side to have a bowel movement and stated she fell out the bed. She stated Resident # 1 liked to be turned on her side when having a bowel movement. The DON stated the staff were able to look at the resident physician order report to see what their care needs are and to see if they are a one person or two persons assist. During an interview on 4/18/2024 at 4:20 p.m. the Admin. revealed she spoke with Resident #1 after the incident and stated Resident #1 stated the staff positioned her differently in the bed and she fell . She stated this was not reported to HHSC because she did not believe that it was intentional. The Admin. stated after she spoke with Resident # 1 that was the extent of her investigation. The Admin. stated she expected staff to position Resident #1 in the center of the bed while on her side and ensure that she was in a safe position before leaving the room. Record review of facility abuse prevention program dated November 2010 which reflected the following: Our residents have the right to be free from abuse and neglect. Our facility is committed to protecting our residents from abuse by anyone included but not necessarily limited to facility staff. Timely and thorough investigation of all reports and allegations of abuse. An (IJ) Immediate Jeopardy was identified on 4/18/2024 at 6:07pm., due to the above failures. The ADM was notified on 4/18/2023. The ADM was provided with the (IJ) Immediate Jeopardy template on 4/18/2023 at 6:07pm, and a Plan of Removal (POR) was requested. The Plan of removal accepted on 4/19/2024 at 1:26 p.m. and indicated the following: Plan of Removal Date Initiated: 4/18/2024 and accepted on 4/19/2024. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents #1 was assessed by DON and support was provided as accepted. Resident was informed that she would not be left alone during care. Resident was reminded that call light is available if she is concerned about safety. The physician was notified of the deficiencies cited on 4/18/2024. There were no new orders obtained. The affected resident's responsible party was notified by DON of the cited deficiencies and the plan of removal. CNA A was immediately suspended by DON and Administrator on 4/18/2024. CNA A will be terminated due to not following policy and procedures. On 4/18/2024 the DON (director of nursing) and Administrator interviewed all residents in the facility to determine if any other residents needed any assistive devices or had any concerns regarding staff not supervising during care. There were no concerns identified. The interviews were completed before midnight on 4/18/2024. Ad-Hoc (for this situation) QAPI meeting was held on 4/18/2024, with the Medical Director, NHA (Nursing Home Administrator), COO (Chief Operating Officer) and DON to review the cited deficiencies, policy and procedure, and the plan for removal of immediacy. On 4/18/2024 the COO completed 1:1 in-service on Abuse, Neglect and Incident and Accident Reporting with Administrator, DON, and ADON. The in-service also reviewed the importance of providing adequate supervision to residents during care. Starting on 4/18/24, the facility leadership (Administrator, DON, and ADON) will complete education with nursing staff on incidents and accidents and supervision. The leadership team also in serviced on reporting any incidents and accidents immediately to ensure that each resident receives the services consistent with the professional standards of practice. DON/designee reviewed the resident profiles to include the resident care plan. In servicing from DON and/or designee with direct care staff on how to access profiles in the Point of Care system. The in-services were consistent with nursing staff to be able to identify the type of care each resident needs for ADLs. The training was initiated on 4/18/24 and will be completed on 4/18/24. Nursing staff will give a return demonstration on how to pull profiles in the EMR and Point of Care system. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. Staff will not be allowed to work until they receive training. The policy pertaining to Incident, Accidents and supervision were reviewed on 4/18/24 by the DON, NHA (Nursing Home Administrator) and Medical Director. Current policy was reviewed with staff to ensure compliance. Starting on 4/18/24, IDT (Interdisciplinary team), including Administrator, DON, ADON, Activity Director, MDS Coordinator, HR, BOM) will meet with all residents daily Monday to Friday, and Manager on Duty Saturday and Sunday to determine if any residents have any concerns on supervision during care or if any resident had an incident or accident that was not reported. Any concerns identified will be immediately brought to Administrator for further action, if necessary. All incidents and accidents will be documented in the electronic medical record. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/18/24 the COO will start reviewing any incidents or accidents to ensure complete investigation/reporting weekly for four (4) weeks followed by monthly reviews after. The DON/designee will monitor compliance by completing an audit of ten (10) residents per week for four (4) weeks. This was initiated on 4/18/24. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance. The Administrator will be responsible for ensuring this plan is completed on 4/18/24. The COO will provide oversight of DON and Administrators to ensure that the items on the plan of removal are reviewed and completed. Monitoring of POR on 4/19/2024 included the following: During an observation and interview on 4/19/2024 at 11:20 a.m. Resident #1 was in her room. She stated her mother had just left from visiting with her. She stated she still had pain in her back and wrist. She stated her doctor changed her PRN pain medications to every 12 hours. She stated it does not take staff a long time to answer her call light. She stated CNA J is especially fast. She stated she is not complaining, just mad that the Aide walked out and left her on her side without returning. During an interview on 4/19/2024 at 11:45 a.m. LVN C revealed they were in-serviced over the following at the Nursing Station: Abuse Prevention Program, Incident and Accident Reporting If you suspect or witness anything, inform the ADM and DON. She understands the protocol as she has been a nurse for over [AGE] years. You must make sure the safety of the resident is the main thing and you do whatever is necessary to protect them and keep them safe. If she needed further guidance, she would refer to her DON. During an interview on 4/19/2024 at 12:05 p.m. CNA D provided the following information: Abuse Prevention Program, Incident and Accident Reporting She had been a CNA for [AGE] years and she knows every time someone says they fell , she sees them on the floor, or if report they have been neglected, you are supposed to report it immediately to the Nurse, the DON, and the ADM (ANE Coordinator). She said she had never had to report any abuse or neglect other than a fall. She did not learn anything new, it was more of a refresher. During an interview on 4/19/2024 at 12: 25 p.m. CNA F. She provided the following information: Abuse Prevention Program, Incident and Accident Reporting (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	They were told the signs of abuse and neglect, what to look for and who to report it to. They were told how to protect the resident until it is reported, and they are assessed. She did not learn anything new. It was more of a re-education as she had been in this field since 1999. It was the same information that she remembers. She stated she took away that abuse can also be between two residents, and you must remember what may seem minor to you, the resident can be affected negatively. During an interview on 4/19/2024 at 12:40 p.m. CNA E indicated he was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting He stated they gave everyone their own copy of each in-service. He stated they went over who to contact and what to do if it was an actual incident. He stated he knows any form of abuse and neglect needs to be reported. They have the signs of abuse and neglect posted on the wall by the time clocks and at the beginning of the 200 halls. He stated he did not learn anything new; it was more of a re-education. He stated he oversees the CNAs and conduct in-services with them. During an interview on 4/19/2024 at 12:55 p.m. LVN T. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if you see anything, you must report it to the ADM. You must chart it and fill out an event report. If you see any signs of abuse or neglect you should intervene if you witness it. She learned that locking a resident's wheelchair could be a form of abuse if they are mobile and they cannot unlock the wheelchair themselves. During an interview on 4/19/2024 at 1:20 p.m. CNA K. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if there is a sign of abuse or neglect you must contact the ADM. If you cannot get a hold of her in 10-15 minutes, you must contact the DON because they must report within 2 hours. She stated if you see something you must say something. She stated she has been working in facilities for over 5 years and did not learn anything new. She stated it was more of a reminder. During an interview on 4/19/2024 at 1:40 p.m. the DON provided the following information: Ad Hoc QAPI Meeting She stated they discussed the two Tags and discussed the resident of concern with the PCP. She stated they asked if he wanted anything changed to the policy, and he stated there was nothing at this time. She stated they informed him the CNA was suspended, pending termination. Safe Surveys (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated herself, the MDS Coordinator and the ADON completed the Safe Surveys with each resident. She stated there were no concerns regarding abuse or neglect. She stated one female resident mentioned the Aides talk a lot. She stated one male resident said the Aide of Concern is a little gruff in speaking. She stated to eradicate this, the Aide is being terminated. She stated she will be doing more monitoring over the weekends on the halls and asking random residents about their care. Abuse Prevention Program, Incident and Accident Reporting She stated they went over all parts of the policy and the protection of residents. She stated they went over who to report it to and although they tell the nurse, they must still report it to the DON and the ADM themselves. She provided them a list of signs and symptoms and how the resident may react to being abused. She gave them examples of depression to know what to watch for with a resident. She stated it is not always verbal or physical, but it could be mental abuse, misappropriation, etc. During an interview on 4/19/2024 at 2:00 p.m. the Admin. provided the following information: Ad Hoc QAPI Meeting She stated they went over interviewing all residents for supervision related to incidents and accidents. She stated they discussed in-servicing all staff on Abuse and Neglect, Reporting, Incidents and Accidents. She stated staff not present would be called to provide education over the phone. She stated the IDT team reviewed all residents for abuse, and neglect to include supervision. She stated they discussed policy of ANE, Reporting, Incidents and Accidents. She stated no changes have been made and no new policies were created. She stated they reviewed the Plan of Removal with all attendees. She stated the COO in-serviced her, the DON and the ADON. She stated this morning, the Resident of Concern wanted to be left alone during her bowel movement and they had to re-educate her that it was not safe to do so. She stated the Resident was fine with the decision due to her safety. She stated due to taking a lot of pain medications, it causes the Resident to become constipated. She stated laying on her side, helps it to release. Safe Surveys She stated they completed Safe Survey Audits and spoke with every Resident at the facility. She stated only 2 mentioned that they did not care for the Aide Resident # 3 and Resident #4 stated due to the way she talks. She stated they were never harmed; they just did not care for her demeanor. She stated due to their feedback along with the incident with Resident # 1, they are moving forward with termination. She stated she is currently suspended, and her termination has been approved and will occur this afternoon via phone. Record review of in-service dated 4/18/2024 on Resident Rights completed by 38 staff. Record review of in-service dated 4/18/2024 on Positioning and Re-positioning residents in bed completed by 12 CNA and nursing staff. Record review of progress note dated 4/15/2024 regarding assessment of Resident # 1's hand/wrist, right leg and ankle. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/19/2023 at 1:29 p.m., the ADM was informed the (IJ) Immediate Jeopardy was removed. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:29 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44526 Based on observation, interview, and record review the facility failed to ensure adequate supervision and assistive devices to prevent accidents for 1(Resident #1) of 6 residents reviewed for accidents and supervision. The facility failed to ensure on 4/14/2024 that Resident # 1 was repositioned in her bed by CNA A, who placed her too close to the edge of the bed. The lack of supervision resulted in that Resident # 1 fell out her bed and sustained a fractured right wrist, swollen right side of her face, and other scratches to her legs from the fall. Resident # 1's right wrist was placed in a brace, and she was prescribed pain medication as needed. This failure resulted in an identification of an (IJ) Immediate Jeopardy on 4/18/2024 at 6:07 p.m. The IJ Immediate Jeopardy template was provided to the ADM on 4/18/2024 at 6:07 p.m. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:26 p.m., the facility remained out of compliance at a scope of isolated and severity level of actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting. This failure could place residents at risk for accidents and harm. Findings included: Record review of Resident #1's face sheet dated 1/9/2024 reflected, Resident #1 is a [AGE] year-old female who was admitted to the facility on [DATE]. The face sheet reflected Resident #1 had the following diagnoses Other acute osteomyelitis (bone inflammation that can result in pelvis trauma), left femur, Muscle wasting and atrophy (wasting, thinning or loss of muscle tissue), not elsewhere classified, right upper arm, Muscle wasting and atrophy (muscle that lose their nerve supply), not elsewhere classified, left upper arm, Chronic pain syndrome (other symptoms beyond pain alone), Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), Functional quadriplegia(Complete Immobility due to sever disability or frailty from another medical condition without injury to the spinal cord). Record review of Resident's #1 admission MDS dated [DATE] BIMS score 15 cognitive intact GG functional section of MDS reflect the resident required substantial /maximal assistance with roll to left or right side. Record review of Resident #1 care plan dated 1/18/2024 reflected Resident # 1 required total staff performs /provides total assistance for all ADL's. The care plan reflected the following interventions: Keep call light within reach and encourage use for assistance. Respond promptly to all request for assistance. Resident # 1 required a bed with side rails on both sides. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of physician order dated 3/24/2024 for Resident # 1 reflected Resident #1 required a 2 x person assist and hoyer for transfers, mobility, bathing, and a 2 x person assist with toileting. During an interview on 4/18/2024 at 11:17 a.m. a FM revealed Resident #1 called her last night 4/17/2024 and stated she fell out the bed on Sunday night 4/14/2024. The FM stated they did not make sure that she was in the center of the bed, she was on the edge and fell out the bed. The FM stated Resident #1 sustained a hairline fracture to her right wrist, she stated she also had a scar on her leg from where she fell and that he was swollen on the right side. The FM stated Resident # 1 was in a lot of pain because usually she did not cry but stated she was crying because of the pain from her injuries. During an interview on 4/18/2024 at 11:46 a.m. Resident #1 revealed on Sunday 4/14/2024 CNA A repositioned her on her left side and pulled her all the way to the edge of the bed and left the room. Resident # 1 stated when she realized she was falling she yelled out help- help. Resident # 1 stated there was another bedside table in the room and when she fell her face hit the table and then the floor, stated her leg also hit the table. Resident #1 stated she tried to brace her fall by putting her hand out and fractured her wrist. Resident #1 stated she was still in pain today and the facility was giving her medication to help with the pain. During an interview on 4/18/2024 at 3:45 p.m. CNA B revealed she did work the night of the incident. She stated Resident # 1 told her that CNA A turned her and pulled her too close to edge of the bed and she fell . She stated they do turn Resident #1 to her side when having a bowel movement but stated there is someone in the front and on the other side of the bed and they stay with the resident. During an interview on 4/18/2024 at 4:00 p.m. the DON, revealed she was advised of the fall the next day on 4/15/2024. The DON stated nursing staff reported Resident # 1 was turned on left side to have a bowel movement and stated she fell out the bed. She stated Resident # 1 liked to be turned on her side when having a bowel movement. The DON stated the staff were able to look at the resident physician order report to see what their care needs are and to see if they are a one person or two persons assist. During an interview on 4/18/2024 at 4:20 p.m. with the Admin. revealed she spoke with Resident #1 after the incident and Resident #1 stated the staff positioned her differently in the bed and she fell . She stated this was not reported to HHSC because she did not believe that it was intentional. The Admin. stated that was the extent of their investigation. Record Review of medical record dated 4/15/2024 of X-ray of the right wrist reflected Resident # 1 sustained a Complex intra-articular fracture of the meta-diaphyseal segment of the radius (common orthopedic injuries) Physicians order dated 4/15/2024 reflect portable R wrist XR D/T C/O pain. Physicians order dated 4/16/2024 reflected a brace to right hand /wrist at all times , floor mat to right side of the bed while in bed , check placement q shift Physicians order dated 4/18/2024 reflected hydrocodone -acetaminophen 1 tab every 8 hours. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of nurse's progress note dated 4/15/2024 reflected the following: 2pm-10pm CNA yelled from hall for a nurse. CNA stated she heard a loud thud from the hall, then upon entering resident's room, found her on the floor. Noted resident lying in a fetal position on right side between bed and wall. Resident moaning in pain, stated I think I broke my wrist. Also states she hit the right side of face on floor as well. Took vitals upon assessment and had her placed back into bed. B/P: 113/80; HR: 106bpm; T: 97.4F; O2 Sat: 98%. States she was placed on left edge of bed to have a BM, then was just left there. States she felt herself falling began to call for help, then fell out of bed, hit right side of face on bedside table, then landed on right wrist as it was hyperextended backwards. Upon assessment, noted redness to right side of face over the cheek bone area without swelling. Resident able to symmetrically move facial muscles. C/o tenderness upon palpation. Denies any dizziness or HA. Noted redness accompanied by swelling to right wrist with limited ROM. Applied ice to injured wrist and administered 1 tablet of Norco 10-325mg PO PRN as ordered for pain. No other injuries noted. States I do not want to go to any hospital. Record review of facility abuse prevention program dated November 2010 which reflected the following: Our residents have the right to be free from abuse and neglect. Our facility is committed to protecting our residents from abuse by anyone included but not necessarily limited to facility staff. Timely and thorough investigation of all reports and allegations of abuse. The Admin. was notified on 4/18/2024 at 6:07 p.m., An (IJ) Immediate Jeopardy was identified due to the above failures. The ADM was provided with the (IJ) Immediate Jeopardy template on 4/18/2023 at 6:07pm, and a Plan of Removal (POR) was requested. The Plan of removal accepted on 4/19/2024 at 1:26 p.m. and indicated the following: Plan of Removal Date Initiated: 4/18/2024 and accepted on 4/19/2024. Residents #1 was assessed by DON and support was provided as accepted. Resident was informed that she would not be left alone during care. Resident was reminded that call light is available if she is concerned about safety. The physician was notified of the deficiencies cited on 4/18/2024. There were no new orders obtained. The affected resident's responsible party was notified by DON of the cited deficiencies and the plan of removal. CNA A was immediately suspended by DON and Administrator on 4/18/2024. CNA A will be terminated due to not following policy and procedures. On 4/18/2024 the DON (director of nursing) and Administrator interviewed all residents in the facility to determine if any other residents needed any assistive devices or had any concerns regarding staff not supervising during care. There were no concerns identified. The interviews were completed before midnight on 4/18/2024. Ad-Hoc (for this situation) QAPI meeting was held on 4/18/2024, with the Medical Director, NHA (Nursing Home Administrator), COO (Chief Operating Officer) and DON to review the cited deficiencies, policy and procedure, and the plan for removal of immediacy. (continued on next page)

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	675096	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Homestead Nursing and Rehabilitation of Hillsboro	1725 Old Brandon Rd Hillsboro, TX 76645

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/18/2024 the COO completed 1:1 in-service on Abuse, Neglect and Incident and Accident Reporting with Administrator, DON, and ADON. The in-service also reviewed the importance of providing adequate supervision to residents during care. Starting on 4/18/24, the facility leadership (Administrator, DON, and ADON) will complete education with nursing staff on incidents and accidents and supervision. The leadership team also in serviced on reporting any incidents and accidents immediately to ensure that each resident receives the services consistent with the professional standards of practice. DON/designee reviewed the resident profiles to include the resident care plan. In servicing from DON and/or designee with direct care staff on how to access profiles in the Point of Care system. The in-services were consistent with nursing staff to be able to identify the type of care each resident needs for ADLs. The training was initiated on 4/18/24 and will be completed on 4/18/24. Nursing staff will give a return demonstration on how to pull profiles in the EMR and Point of Care system. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. All staff to include PRN, new employees and agency staff will receive training prior to working the floor and giving direct care. Staff will not be allowed to work until they receive training. The policy pertaining to Incident, Accidents and supervision were reviewed on 4/18/24 by the DON, NHA (Nursing Home Administrator) and Medical Director. Current policy was reviewed with staff to ensure compliance. Starting on 4/18/24, IDT (Interdisciplinary team), including Administrator, DON, ADON, Activity Director, MDS Coordinator, HR, BOM) will meet with all residents daily Monday to Friday, and Manager on Duty Saturday and Sunday to determine if any residents have any concerns on supervision during care or if any resident had an incident or accident that was not reported. Any concerns identified will be immediately brought to Administrator for further action, if necessary. All incidents and accidents will be documented in the electronic medical record. On 4/18/24 the COO will start reviewing any incidents or accidents to ensure complete investigation/reporting weekly for four (4) weeks followed by monthly reviews after. The DON/designee will monitor compliance by completing an audit of ten (10) residents per week for four (4) weeks. This was initiated on 4/18/24. Any identified concern will be addressed immediately and if trends and patterns are identified, the facility will conduct an Ad-Hoc QAPI meeting to discuss if additional interventions are needed to ensure compliance. The Administrator will be responsible for ensuring this plan is completed on 4/18/24. The COO will provide oversight of DON and Administrators to ensure that the items on the plan of removal are reviewed and completed. Monitoring of POR on 4/19/2024 included the following: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 4/19/2024 at 11:20 a.m. Resident #1 was in her room. She stated her mother had just left from visiting with her. She stated she still had pain in her back and wrist. She stated her doctor changed her PRN pain medications to every 12 hours. She stated it does not take staff a long time to answer her call light. She stated CNA J is especially fast. She stated she is not complaining, just mad that the Aide walked out and left her on her side without returning. During an interview on 4/19/2024 at 11:45 a.m. LVN C revealed they were in-serviced over the following at the Nursing Station: Abuse Prevention Program, Incident and Accident Reporting If you suspect or witness anything, inform the ADM and DON. She understands the protocol as she has been a nurse for over [AGE] years. You must make sure the safety of the resident is the main thing and you do whatever is necessary to protect them and keep them safe. If she needed further guidance, she would refer to her DON. Residents Rights She stated residents have the right to refuse any services and they cannot force them. She stated it was a re-education for her. She stated they can refuse to eat, not comply with therapy. If they refuse something dealing with a safety concern, she will chart it and inform the DON. She learned today that they can refuse to allow you to go through their personal belongings and if you do so anyway, you would be infringing upon their rights. Residents Profile and Care Plans She stated they went over the POC in Matrix. You go under the resident's name and click on their Care Plan. The Care Plan has everything pertaining to their care. If you have any questions about their care, this is where you would go. She stated the Aides also had access to POC and the Care Plan. She stated she was already aware, and it was more of a re-education. Positioning and Repositioning Residents in Bed She stated you can also find this information in the Care Plan. They should always be positioned in the center of the bed. Some residents reposition themselves even though they are educated on the correct form for safety. She stated if they are not compliant, she would chart the non-compliance in Matrix and inform the DON. During an interview on 4/19/2024 at 12:05 p.m. CNA D provided the following information: Abuse Prevention Program, Incident and Accident Reporting She had been a CNA for [AGE] years and she knows every time someone says they fell , she sees them on the floor, or if report they have been neglected, you are supposed to report it immediately to the Nurse, the DON, and the ADM (ANE Coordinator). She said she had never had to report any abuse or neglect other than a fall. She did not learn anything new, it was more of a refresher. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents Rights She stated residents have the right to refuse anything. If they refuse care, you are supposed to report it to the nurse. Again, she did not learn anything new, it was more of a re-education. She was in-serviced by the DON. Residents Profile and Care Plans They wanted to make sure they knew how to look up the resident's care. You go under resident task and under their information there is a button for their profile and their Care Plan. She stated it gives you a long list about their daily care, baths, ADLs, how they transfer, their diet, assistance with feeding, etc. She did not learn anything new. Positioning and Repositioning Residents in Bed She stated residents are to be turned every 2 hours. You always make sure the resident is in the center of the bed and not left on their side. You never leave a resident sitting up or laying too close to the edge of the bed, especially if they are not independent. Before leaving the room, you should make sure they have access to their call light. During an interview on 4/19/2024 at 12: 25 p.m. CNA F. She provided the following information: Abuse Prevention Program, Incident and Accident Reporting They were told the signs of abuse and neglect, what to look for and who to report it to. They were told how to protect the resident until it is reported, and they are assessed. She did not learn anything new. It was more of a re-education as she had been in this field since 1999. It was the same information that she remembers. She stated she took away that abuse can also be between two residents, and you must remember what may seem minor to you, the resident can be affected negatively. Residents Rights You must be careful with the resident and treat them with respect and dignity. They have the right to privacy. They can choose what they want to eat. You must respect their decisions. You cannot force them to take their medications or take a shower. You can only document and inform the nurse. Residents Profile and Care Plans She was shown how to go into their Care Plans. She stated she does not have to pull it up often. It is necessary because all their information is listed (ADLs, mobility, showers, etc.). She stated she knew it was there and it was a refresher for her only. Positioning and Repositioning Residents in Bed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If a resident is not mobile, you must reposition them every 2 hours. You cannot leave them in one position because they can develop a bedsore. You must always make sure they are comfortable and not just leave them. You should never leave them too close to the side of the bed. She took away that when you are in a hurry, you may not have them in the center of the bed, and you need to be mindful and slow down. During an interview on 4/19/2024 at 12:40 p.m. CNA E indicated he was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting He stated they gave everyone their own copy of each in-service. He stated they went over who to contact and what to do if it was an actual incident. He stated he knows any form of abuse and neglect needs to be reported. They have the signs of abuse and neglect posted on the wall by the time clocks and at the beginning of the 200 halls. He stated he did not learn anything new; it was more of a re-education. He stated he oversees the CNAs and conduct in-services with them. Residents Rights He stated they laid the residents rights out for the staff. They have them posted throughout the facility. They went over the Federal and State laws. If they feel if a resident's rights are not being honored, they would contact the DON and the ADM. Residents Profile and Care Plans He assisted with showing the CNAs how to look in POC. He showed them how to pull up the resident's profile and click on the Care Plan. The Aides enter information under the general comments for any refusals or concerns and inform the Nurse. It is the Nurse's jobs to inform the CNAs when there is anything new or changes made to the Care Plan. Positioning and Repositioning Residents in Bed He stated they went over how to move and reposition residents to keep them from rolling and/or falling out of the bed. He stated you must make sure the resident is secure and positioned in the center of the bed. They were also shown how to keep the sheets pulled over the residents. He stated they had already gone over it 2 weeks ago and again starting yesterday, 4/18. During an interview on 4/19/2024 at 12:55 p.m. LVN T. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if you see anything, you must report it to the ADM. You must chart it and fill out an event report. If you see any signs of abuse or neglect you should intervene if you witness it. She learned that locking a resident's wheelchair could be a form of abuse if they are mobile and they cannot unlock the wheelchair themselves. Residents Rights (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated residents are allowed to deny medications, food, showers, etc. If the resident wants to stay in their rooms, they can. The resident has the right to refuse any treatments, but they can encourage them. When residents refuse, you must chart it and inform the DON and the ADM. Residents Profile and Care Plans She stated she can look in Matrix to see the care required for the Resident. She stated it shows how they transfer, the type of diet, etc. The Care Plan shows it they are full code or DNR status. It also has their observations listed. She stated everything is new to her because she has only been a nurse for a few weeks. Positioning and Repositioning Residents in Bed She stated if a resident is immobile, they must be repositioned every 2 hours. Even if they are not immobile but remains in bed a lot they must still reposition them. She stated you can use pillows to elevevate them and always check for any redness. If a resident slides in bed, you must pull them back up in the bed. She stated she was a CNA before becoming a Nurse and already knew the information. During an interview on 4/19/2024 at 1:20 p.m. CNA K. indicated she was in-serviced on the following information: Abuse Prevention Program, Incident and Accident Reporting She stated if there is a sign of abuse or neglect you must contact the ADM. If you cannot get a hold of her in 10-15 minutes, you must contact the DON because they must report within 2 hours. She stated if you see something you must say something. She stated she has been working in facilities for over 5 years and did not learn anything new. She stated it was more of a reminder. Residents Rights She stated residents have the right to refuse. She stated this has always been the most important to her. She stated you cannot force residents to do anything. She stated residents have the right to refuse showers, food, care, medication, etc. She stated they also have the same rights as they did prior to admitting to the facility. She stated if a resident refuses any care or treatment, she will leave and reattempt 2 more times and then report it to the nurse. Residents Profile and Care Plans She stated she was showed how to pull up residents' Care Plans. She stated she did not know prior to today. She stated the Care Plan tells you about the ADLs, their likes, and dislikes, and what they were accustomed to prior to admitting. She stated you can see their shower days and times, diagnosis, etc. She stated the Care Plan enables her to learn more about her residents and how to care for them properly. Positioning and Repositioning Residents in Bed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated she was told to make sure the resident is centered in the bed and there is nothing to restrict their movement so they can do whatever they need to do. She stated you must reposition them every 2 hours. She stated she did not know they were supposed to be centered in the bed, she used to just reposition them in whatever spot they would be laying or sitting. During an interview on 4/19/2024 at 1:40 p.m. the DON provided the following information: Ad Hoc QAPI Meeting She stated they discussed the two Tags and discussed the resident of concern with the PCP. She stated they asked if he wanted anything changed to the policy, and he stated there was nothing at this time. She stated they informed him the CNA was suspended, pending termination. Safe Surveys She stated herself, the MDS Coordinator and the ADON completed the Safe Surveys with each resident. She stated there were no concerns regarding abuse or neglect. She stated one female resident mentioned the Aides talk a lot. She stated one male resident said the Aide of Concern is a little gruff in speaking. She stated to eradicate this, the Aide is being terminated. She stated she will be doing more monitoring over the weekends on the halls and asking random residents about their care. Abuse Prevention Program, Incident and Accident Reporting She stated they went over all parts of the policy and the protection of residents. She stated they went over who to report it to and although they tell the nurse, they must still report it to the DON and the ADM themselves. She provided them a list of signs and symptoms and how the resident may react to being abused. She gave them examples of depression to know what to watch for with a resident. She stated it is not always verbal or physical, but it could be mental abuse, misappropriation, etc. Residents Rights She stated they went through the entire list of residents' rights. She stated they explained them all and asked if they had questions. She stated they also posted a list of the rights at the entrance of the hall. Residents Profile and Care Plans She stated she pulled it up and showed them how to access it. She stated she then had them demonstrate it. She stated she showed the Aides how to access the POC, go to the photo area and the second tab shows the profile (ADLS, showers, dietary, etc.). She stated if a resident has a change, she needs to know so that she can update it in Matrix. She stated she also told them to make sure they inform her of any changes they notice right away. Positioning and Repositioning Residents in Bed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She stated they are educating both Aids and Nurses when they put a resident on their side to make sure they are centered and not too close to the edge of the bed. She stated if they have a draw sheet, they must still make sure they are still centered in the bed. She stated there was nothing new added to the policy, just more of a re-education for all direct care staff. During an interview on 4/19/2024 at 2:00 p.m. the Admin. provided the following information: Ad Hoc QAPI Meeting She stated they went over interviewing all residents for supervision related to incidents and accidents. She stated they discussed in-servicing all staff on Abuse and Neglect, Reporting, Incidents and Accidents. She stated staff not present would be called to provide education over the phone. She stated the IDT team reviewed all residents for abuse, and neglect to include supervision. She stated they discussed policy of ANE, Reporting, Incidents and Accidents. She stated no changes have been made and no new policies were created. She stated they reviewed the Plan of Removal with all attendees. She stated the COO in-serviced her, the DON and the ADON. She stated this morning, the Resident of Concern wanted to be left alone during her bowel movement and they had to re-educate her that it was not safe to do so. She stated the Resident was fine with the decision due to her safety. She stated due to taking a lot of pain medications, it causes the Resident to become constipated. She stated laying on her side, helps it to release. Safe Surveys She stated they completed Safe Survey Audits and spoke with every Resident at the facility. She stated only 2 mentioned that they did not care for the Aide Resident # 3 and Resident #4 stated due to the way she talks. She stated they were never harmed; they just did not care for her demeanor. She stated due to their feedback along with the incident with Resident # 1, they are moving forward with termination. She stated she is currently suspended, and her termination has been approved and will occur this afternoon via phone. Record review of in-service dated 4/18/2024 on Resident Rights completed by 38 staff. Record review of in-service dated 4/18/2024 on Positioning and Re-positioning residents in bed completed by 12 CNA and nursing staff. Record review of progress note dated 4/15/2024 regarding assessment of Resident # 1's hand/wrist, right leg and ankle. On 4/19/2023 at 1:29 p.m., the ADM was informed the (IJ) Immediate Jeopardy was removed. While the (IJ) Immediate Jeopardy was removed on 4/19/2024 at 1:29 p.m., the facility remained out of compliance at a scope of isolated and severity level of no actual harm because all staff had not been trained on abuse/neglect, incident/accidents, and reporting.