STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675117	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runningwater Draw Care Center Inc	800 W 13th St Olton, TX 79064

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on interview and record review the facility failed to ensure each resident was free from neglect for 1 of 6 residents (Resident #1) reviewed for neglect. The facility failed to ensure Resident #1 was free from neglect. On 5/15/24 after lunch, CNA B performed a 1-person transfer of Resident #1, who was a 2-person transfer. The transfer resulted in CNA B and Resident #1 falling to the floor, causing the fracture of Resident #1's right femur. CNA B did not report the fall. CNA C, who was in the room with CNA B at the time of the incident, did not report the fall until approximately 7 hours after the inappropriate transfer and fall occurred. This failure could place residents at risk of major injury due to neglect in their care. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/15/24 at approximately 1:30PM and ended on 5/16/24 at 9:53AM. The facility had corrected the non-compliance before the survey began. Findings included: Record review of Admission Notes revealed Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with a BIMS score of 03, indicating severe cognitive impairment and a diagnoses of complete transverse atypical (abnormal) femoral (femur) fracture, right leg, sequela (consequence of previous disease), unspecified osteoarthritis (degenerative joint disease, in which the joint breaks down over time), unspecified site, pain in unspecified knee, other abnormalities of gait and mobility, repeated falls, presence of right artificial knee joint, and non-displaced fracture of greater trochanter (outside hip joint) of right femur. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1's Quarterly Care Plan dated 4/20/24 revealed an ADL self-care performance deficit related to Osteoarthritis, Abnormalities of Gait, Weakness and Right Femur Fracture. She had bilateral lower extremity contractures at the knee, which required the use of Podus Boots (lightweight, quality plastic shell brace with poly/pile liner) to both feet to prevent skin breakdown. Resident #1 required total assistance x 2 staff for all transfers and movement between surfaces. Resident #1 required the use of a Geri chair (a wheelchair designed for resident who may need a more substantial, and many times less restrictive, seating platform.) for mobility and postural support related to hip fracture. Resident #1 was at moderate risk for falls related to Alzheimer's Disease, along with weakness and contracture to her legs. A chair alarm was required while Resident #1 was seated, and a bed alarm was required while Resident #1 was in bed. Both were used to encourage safety awareness. Resident #1 required a fall mat at her bedside, while in bed, to decrease the risk of injury from falls. The resident's call light was to be in place and working at all times. Resident #1 had chronic pain related right knee and hip and was prescribed pain medications, including Tramadol, an opioid, to relieve discomfort. Review of Vista Teleradiology notes dated 5/15/24 revealed an x-ray was taken of Resident #1's right leg at 10:16PM. Findings were as follows: Bones: There is a mildly displaced metaphyseal fracture along the distal femoral bone, at the edge of the femoral prosthesis cap. Total left hip prosthesis changes. No sclerotic or destructive changes observed. Soft tissues: Joint effusion. Impression: Mild displaced metaphyseal fracture at the distal femoral bone, at the edge of the femoral prosthesis cap. Record Review of facility Progress Notes dated 5/15/24 revealed Resident #1 sustained a complete transverse atypical femoral fracture to her right leg when CNA B attempted a 1-person transfer of Resident #1 (who was a 2-person assist for all ADL s according to the MDS and Care Plan dated 4/20/24), which resulted in both falling to the floor. CNA C was also in the resident's room at the time of the incident, caring for Resident #2, and did not witness what took place. Record Review of facility in-services for the last 90 days revealed training on Abuse/Neglect, and Transfer of Residents had taken place for all staff on 5/14/24, the day prior to the incident. CNA B and CNA C attended this in-service. On 5/30/24 at 9:38AM an interview with the Administrator revealed on 5/14/24 staff had been in-serviced on resident abuse and neglect, and transfer of residents. She stated on 5/15/24 at approximately 1:30PM, CNA B attempted a 1-person transfer of Resident #1, which resulted in both falling to the floor. CNA B, along with CNA C, who was in the resident's room at the time of the incident, failed to report the fall to facility staff, resulting in Resident #1 not being assessed by nursing staff. Sometime between the hours of 8:00PM and 8:30PM on 5/15/24, CNA C called LVN A to report the incident, after her shift had ended. LVN A immediately called the DON and the DON arrived at the facility at approximately 9:15PM to assess Resident #1. It was determined that an x-ray was required, and the mobile x-ray service arrived at the facility at approximately 10:15PM. At approximately 1:30AM, the facility received the results of the x-ray and a fracture to the right femur was confirmed. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview with Resident #1's Representatives on 5/30/24 at 11:52AM revealed the facility had informed them of Resident #1's fall late in the evening of 5/15/24, and due to the late hour of the incident, requested that their resident not be transferred to the hospital, until morning. RR stated approximately 9:40AM on 5/16/24, Resident #1 was transported to the hospital via ambulance, where the fracture to the right femur was again confirmed, through x-ray. It was determined that the fracture was inoperable due to a prior knee replacement which took place in October of 2022, along with a previous fracture of the right hip, which took place in November of 2022. A leg immobilizer and additional pain medication were ordered, and the resident was returned to the facility. Record review revealed Resident #1's Care Plan was updated on 5/16/24 to include the use of the leg immobilizer to her right leg and palliative care, including Morphine Sulfate, after the fall on 5/15/24. These measures were put into place to prevent any further contracture to the right leg and relieve residual pain. Multiple observations throughout the investigation on 5/30/24 and 5/31/24 revealed that above each occupied resident bed was a sign indicating what type of transfer each resident required. Multiple staff interviews throughout the investigation on 5/30/24 and 5/31/24 revealed that staff had received extensive training on 5/14/24 and 5/16/24 on abuse and neglect, reporting requirements, appropriate transfers and procedures to follow if a resident falls during a transfer. These interviews revealed that as a result of the incident, competency checks on transfers were initiated and completed for all staff on 5/16/24. Record review of CNA B's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1, the resulting fall and failure to report The Employee Warning Notice indicated that CNA B declined to write a statement. In the action to be taken section of the Employee Warning Notice, dismissal was checked. CNA B's employment with the facility was terminated on 5/16/24. Record review of CNA C's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1, CNA C's initial failure to report the subsequent fall. The Employee Warning Notice indicated that CNA C declined to write a statement. In the action to be take section of the Employee Warning Notice, other was checked and the following statement was written: Suspension x 2 weeks. Consequence should incident occur again - additional disciplinary action up to termination. CNA C was immediately suspended for 2 weeks. Record Review of in-services for the last 90 days revealed staff were again in-serviced on Abuse/Neglect and Transfer of Residents on 5/16/24. The subject matter of these inservices included requirements for reporting any suspected abuse or neglect, responsibilities for reporting, what to report and who to report to, appropriate transfer of residents using the required number of staff and what to do in the event that a resident falls during a transfer. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the CNA Supervisor on 5/30/24 at 3:10PM revealed CNA B was not in attendance for these additional in-services due to being terminated from her position the morning of 5/16/24 and CNA C was not in attendance due to being placed on two-weeks leave without pay. The CNA Supervisor stated she had no prior issues with CNAs and suspected neglect of residents. She stated at the Stand Up meeting on the morning of 5/16/24 she was informed by an unnamed CNA, that Resident #1 had been dropped by CNA B, the previous day. CNA Supervisor then spoke with other facility staff to gain insight into what had happened to Resident #1. When CNA Supervisor spoke with CNA B, she could not explain what had happened to Resident #1 other than she had tried to transfer Resident #1 by herself, and both had fallen to the floor. CNA B stated she had panicked and didn't know what to do. She was aware she had done something bad but had not reported it and had asked CNA C to not report the incident, as well. CNA B was immediately terminated, and CNA C was placed on leave without pay, pending the internal investigation. An interview with CNA C on 5/30/24 at 3:22PM revealed CNA C had been present in the room at the time of the incident, but had not seen what had taken place, due to providing care to Resident #1's roommate. CNA C stated both she and CNA B had worked the 5AM-5PM shift and had left the faciity on the day of the incident at their usual departure time of 5PM. Between the hours of 8:00PM and 8:30PM on 5/15/24, CNA C called LVN A and confessed to the fall taking place earlier that day, during her shift. She stated she had attended the in-service on Abuse/Neglect and Transfer of Residents on 5/14/24. Multiple attempts were made to speak with CNA B. These calls were not returned. Record Review of facility policy for Resident Neglect, dated July 10,2019 defined neglect as: The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Furthermore, it is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional anguish. To determine whether neglect may have occurred, a NF must decide if an injury, emotional harm, pain or death of a resident was due to the NF's failure to provide goods or services to a resident. Example of neglect: A resident, per his care plan, requires a two-person transfer from his bed to a chair. Only one staff member assists the resident in transferring him from his bed to a chair and the resident falls, resulting in extensive bruising to his thigh that was determined to be a serious injury. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/15/24 at approximately 1:30PM and ended on 5/16/24 at 9:53AM. The facility had corrected the non-compliance before the survey began.

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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 - Immediate jeopardy to resident health or safety 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** 47159 Based on interview and record review the facility failed to ensure that all allegations involving neglect are reported immediately, but no later than 2 hours after the event, if the resident sustains serious bodily injury, to the Administrator of the facility and the State Survey Agency for 1 of 6 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect for Resident #1 within 2 hours of the event. CNA C did not report a fall with potential injury until approximately 7 hours after the inappropriate transfer and fall occured. CNA B did not report the fall. This failure could place residents at risk of not having incidents of neglect reported and investigated in a timely manner and delay in proper treatment of injury. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/15/24 at approximately 1:30PM and ended on 5/16/24 at 9:53AM. The facility had corrected the non-compliance before the survey began. Findings included: Record review of Admission Notes revealed Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with a BIMS score of 03, indicating severe cognitive impairment and a diagnoses of complete transverse atypical (abnormal) femoral (femur) fracture, right leg, sequela (consequence of previous disease), unspecified osteoarthritis (degenerative joint disease, in which the joint breaks down over time), unspecified site, pain in unspecified knee, other abnormalities of gait and mobility, repeated falls, presence of right artificial knee joint, and non-displaced fracture of greater trochanter (outside hip joint) of right femur. Resident #1's Quarterly Care Plan dated 4/20/24 revealed an ADL self-care performance deficit related to Osteoarthritis, Abnormalities of Gait, Weakness and Right Femur Fracture. She had bilateral lower extremity contractures at the knee, which required the use of Podus Boots (lightweight, quality plastic shell brace with poly/pile liner) to both feet to prevent skin breakdown. Resident #1 required total assistance x 2 staff for all transfers and movement between surfaces. Resident #1 required the use of a Geri chair (a wheelchair designed for resident who may need a more substantial, and many times less restrictive, seating platform.) for mobility and postural support related to hip fracture. Resident #1 was at moderate risk for falls related to Alzheimer's Disease, along with weakness and contracture to her legs. A chair alarm was required while Resident #1 was seated, and a bed alarm was required while Resident #1 was in bed. Both were used to encourage safety awareness. Resident #1 required a fall mat at her bedside, while in bed, to decrease the risk of injury from falls. The resident's call light was to be in place and working at all times. Resident #1 had chronic pain related right knee and hip and was prescribed pain medications, including Tramadol, an opioid, to relieve discomfort. Record Review of x-ray notes dated 5/15/24 revealed an x-ray was taken of Resident #1's right leg at 10:16PM. Findings were as follows: (continued on next page)

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Runningwater Draw Care Center Inc	800 W 13th St Olton, TX 79064

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Bones: There is a mildly displaced metaphyseal fracture along the distal femoral bone, at the edge of the femoral prosthesis cap. Total left hip prosthesis changes. No sclerotic or destructive changes observed. Soft tissues: Joint effusion. Impression: Mild displaced metaphyseal fracture at the distal femoral bone, at the edge of the femoral prosthesis cap. Record Review of facility Progress Notes dated 5/15/24 revealed Resident #1 sustained a complete transverse atypical femoral fracture to her right leg when CNA B attempted a 1-person transfer of Resident #1 (who was a 2-person assist for all ADL s according to the MDS and Care Plan dated 4/20/24), which resulted in both falling to the floor. CNA C was also in the resident's room at the time of the incident, caring for Resident #2, and did not witness what took place. Record Review of facility in-services for the last 90 days revealed training on Abuse/Neglect, and Transfer of Residents had taken place for all staff on 5/14/24, the day prior to the incident. CNA B and CNA C attended this in-service. Record Review of in-services for the last 90 days revealed staff were again in-serviced on Abuse/Neglect and Transfer of Residents on 5/16/24. The subject matter of these inservices included requirements for reporting any suspected abuse or neglect, responsibilities for reporting, what to report and who to report to, appropriate transfer of residents using the required number of staff and what to do in the event that a resident falls during a transfer. On 5/30/24 at 9:38AM an interview with the Administrator revealed on 5/14/24 staff had been in-serviced on resident abuse and neglect, and transfer of residents. She stated on 5/15/24 at approximately 1:30PM, CNA B attempted a 1-person transfer of Resident #1, which resulted in both falling to the floor. CNA B, along with CNA C, who was in the resident's room at the time of the incident, failed to report the fall to facility staff, resulting in Resident #1 not being assessed by nursing staff. Sometime between the hours of 8:00PM and 8:30PM on 5/15/24, CNA C called LVN A to report the incident, after her shift had ended. LVN A immediately called the DON and the DON arrived at the facility at approximately 9:15PM to assess Resident #1. It was determined that an x-ray was required, and the mobile x-ray service arrived at the facility at approximately 10:15PM. At approximately 1:30AM, the facility received the results of the x-ray and a fracture to the right femur was confirmed. A phone interview with Resident #1's Representatives on 5/30/24 at 11:52AM revealed the facility had informed them of Resident #1's fall late in the evening of 5/15/24, and due to the late hour of the incident, requested that their resident not be transferred to the hospital, until morning. RR stated approximately 9:40AM on 5/16/24, Resident #1 was transported to the hospital via ambulance, where the fracture to the right femur was again confirmed, through x-ray. It was determined that the fracture was inoperable due to a prior knee replacement which took place in October of 2022, along with a previous fracture of the right hip, which took place in November of 2022. A leg immobilizer and additional pain medication were ordered, and the resident was returned to the facility. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed Resident #1's Care Plan was updated on 5/16/24 to include the use of the leg immobilizer to her right leg and palliative care, including Morphine Sulfate, after the fall on 5/15/24. These measures were put into place to prevent any further contracture to the right leg and relieve residual pain. An interview with the CNA Supervisor on 5/30/24 at 3:10PM revealed CNA B was not in attendance for these additional in-services due to being terminated from her position the morning of 5/16/24 and CNA C was not in attendance due to being placed on two-weeks leave without pay. The CNA Supervisor stated she had no prior issues with CNAs and suspected neglect of residents. She stated at the Stand Up meeting on the morning of 5/16/24 she was informed by an unnamed CNA, that Resident #1 had been dropped by CNA B, the previous day. CNA Supervisor then spoke with other facility staff to gain insight into what had happened to Resident #1. When CNA Supervisor spoke with CNA B, she could not explain what had happened to Resident #1 other than she had tried to transfer Resident #1 by herself, and both had fallen to the floor. CNA B stated she had panicked and did not know what to do. She was aware she had done something bad but had not reported it and had asked CNA C to not report the incident, as well. CNA B was immediately terminated, and CNA C was placed on leave without pay, pending the internal investigation. An interview with CNA C on 5/30/24 at 3:22PM revealed CNA B had asked her to not report the incident to facility staff. CNA C stated both she and CNA B had worked the 5AM-5PM shift and had left the faciity on the day of the incident at their usual departure time of 5PM, without notifying staff of the fall. Between the hours of 8:00PM and 8:30PM on 5/15/24, CNA C called LVN A and confessed to the fall taking place earlier that day, during her shift. CNA B had not reported the incident to facility staff. CNA B was immediately terminated, and CNA C was placed on leave without pay, pending the internal investigation. Multiple attempts were made to speak with CNA B. These calls were not returned. Multiple observations throughout the investigation on 5/30/24 and 5/31/24 revealed that above each occupied resident bed was a sign indicating what type of transfer each resident required. Record review of CNA B's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1. The Employee Warning Notice indicated that CNA B declined to write a statement. In the action to be taken section of the Employee Warning Notice, dismissal was checked. CNA B's employment with the facility was terminated on 5/16/24. Record review of CNA C's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1, CNA C's initial failure to report the subsequent fall. The Employee Warning Notice indicated that CNA C declined to write a statement. In the action to be take section of the Employee Warning Notice, other was checked and the following statement was written: Suspension x 2 weeks. Consequence should incident occur again - additional disciplinary action up to termination. CNA C was immediately suspended for 2 weeks. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Multiple staff interviews throughout the investigation on 5/30/24 and 5/31/24 revealed that staff had received extensive training on 5/14/24 and 5/16/24 on abuse and neglect, reporting requirements, appropriate transfers and procedures to follow if a resident falls during a transfer. These interviews revealed that as a result of the incident, competency checks on transfers were initiated and completed for all staff on 5/16/24. Record Review of facility policy for Resident Neglect, dated July 10,2019 defined neglect as: The failure to provide goods or services, including medical services that are necessary to avoid physical or emotional harm, pain, or mental illness. Furthermore, it is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional anguish. To determine whether neglect may have occurred, a NF must decide if an injury, emotional harm, pain or death of a resident was due to the NF's failure to provide goods or services to a resident. Example of neglect: A resident, per his care plan, requires a two-person transfer from his bed to a chair. Only one staff member assists the resident in transferring him from his bed to a chair and the resident falls, resulting in extensive bruising to his thigh that was determined to be a serious injury. Record Review of facility policy for Abuse, Neglect and Reporting/Investigation of Incidents, dated September 2022, revealed the following: Reporting Allegations to the Administrator and Authorities 1. If resident neglect is suspected, the suspicion must be reported immediately to the Administrator and other officials, according to state law. Immediately is defined as within two hours of an allegation involving serious bodily injury or within 24 hours if the allegation does not result in serious bodily injury. 6. Upon receiving any allegation of neglect, the Administrator is responsible for determining what actions (if any) are needed for the protection of residents. Investigating Allegations 1. All allegations are thoroughly investigated. The Administrator initiates investigations. 4. The Administrator is responsible for keeping the resident and his/her representative(s) informed of the progress of the investigation. 6. Any employee who has been accused of resident neglect is place on leave with no further contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: a. reviews documentation and evidence; (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. reviews the resident's medical record to determine the resident's physical and cognitive status at the time of the incident and since the incident; c. observes the alleged victim, including his or her interactions with staff and other residents; d. interviews the person(s) reporting the incident; e. interview any witnesses to the incident; f. interviews the resident (as medically appropriate) or resident's representative; g. interviews resident's attending physician to determine resident's condition; h. interviews staff members on all shifts who have had contact with the resident during the period of the alleged incident; i. interviews the resident's roommate, family members and visitors; j. interviews other residents to whom the accused employee provides care or services; k. reviews all events leading up to the alleged incident; and l. documents the investigation completely and thoroughly. Corrective Actions 1. All relevant professional and licensing boards are notified when an employee is found to have committed abuse/neglect. 2. If the investigation reveals that the allegation(s) are founded, the employee is terminated. 3. Any allegations of abuse/neglect are filed in the accused employee's personnel record along with any statement by the employee disputing the allegation if the employee chooses to make one. 4. Of the investigation reveals that the allegations of abuse/neglect are unfounded, the employee may be reinstated to his/her former position with back pay. 5. Records concerning allegations that are determined to be unfounded are destroyed or archived per human resources policy. 6. Corrective action may include a full review of the incident by the QAPI committee. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/30/24 at 4:40PM and ended on 5/31/24 at 8:30AM. The facility had corrected the non-compliance before the survey began.

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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** 47159 Based on interview and record review the facility failed to ensure that the resident environment remains free of accidents and hazards, as possible, and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #1) reviewed for adequate supervision to prevent accidents and hazards. The facility failed to ensure that Resident #1 was assisted x 2 staff for all transfers and movement between surfaces. CNA B transferred Resident #1 independently which resulted in CNA B and Resident #1 falling to the floor. As a result of the fall, Resident #1 suffered a fractured right leg. This failure could place residents at risk for falls with serious injuries. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/15/24 at approximately 1:30PM and ended on 5/16/24 at 9:53AM. The facility had corrected the non-compliance before the survey began. Findings included: Record review of Admission Notes revealed Resident #1 was a [AGE] year-old female who was admitted to the facility on [DATE] with a BIMS score of 03, indicating severe cognitive impairment and a diagnoses of complete transverse atypical (abnormal) femoral (femur) fracture, right leg, sequela (consequence of previous disease), unspecified osteoarthritis (degenerative joint disease, in which the joint breaks down over time), unspecified site, pain in unspecified knee, other abnormalities of gait and mobility, repeated falls, presence of right artificial knee joint, and non-displaced fracture of greater trochanter (outside hip joint) of right femur. Resident #1's Quarterly Care Plan dated 4/20/24 revealed an ADL self-care performance deficit related to Osteoarthritis, Abnormalities of Gait, Weakness and Right Femur Fracture. She had bilateral lower extremity contractures at the knee, which required the use of Podus Boots (lightweight, quality plastic shell brace with poly/pile liner) to both feet to prevent skin breakdown. Resident #1 required total assistance x 2 staff for all transfers and movement between surfaces. Resident #1 required the use of a Geri chair (a wheelchair designed for resident who may need a more substantial, and many times less restrictive, seating platform.) for mobility and postural support related to hip fracture. Resident #1 was at moderate risk for falls related to Alzheimer's Disease, along with weakness and contracture to her legs. A chair alarm was required while Resident #1 was seated, and a bed alarm was required while Resident #1 was in bed. Both were used to encourage safety awareness. Resident #1 required a fall mat at her bedside, while in bed, to decrease the risk of injury from falls. The resident's call light was to be in place and working at all times. Resident #1 had chronic pain related right knee and hip and was prescribed pain medications, including Tramadol, an opioid, to relieve discomfort. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675117	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runningwater Draw Care Center Inc	800 W 13th St Olton, TX 79064

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed Resident #1's Care Plan was updated on 5/16/24 to include the use of the leg immobilizer to her right leg and palliative care, including Morphine Sulfate, after the fall on 5/15/24. These measures were put into place to prevent any further contracture to the right leg and relieve residual pain after the fall which resulted in fracture. Record review of Resident #1's fall assessment dated [DATE] revealed Resident #1 had intermittent confusion related to Alzheimer's Disease. She had a history of 1-2 falls in the past 3 months. She was chair-bound and required assistance with bowel and bladder voiding. Her vision was adequate without the use of glasses, and she required the use of assistive devices related to gait and balance. Her fall assessment score was 13, indicating she was at high risk for falls and accidents. An interview with the Administrator on 5/30/24 at 9:38AM revealed all staff had been in-serviced on 5/14/24, one day prior to the incident, regarding resident abuse and neglect, reporting of incidents and transfer of residents. She stated on 5/15/24 at approximately 1:30PM, CNA B attempted a 1-person transfer of Resident #1, which resulted in both falling to the floor. CNA B, along with CNA C, who was in the resident's room at the time of the incident, failed to report the fall to facility staff, resulting in Resident #1 not being assessed by nursing staff. Sometime between the hours of 8:00PM and 8:30PM on 5/15/24, CNA C called LVN A to report the incident, after her shift had ended. LVN A immediately called the DON and the DON arrived at the facility at approximately 9:15PM to assess Resident #1. It was determined that an x-ray was required, and the mobile x-ray service arrived at the facility at approximately 10:15PM. At approximately 1:30AM, the facility received the results of the x-ray and a fracture to the right femur was confirmed. At approximately 1:30AM, the facility received the results of the x-ray and a fracture to the right femur was confirmed. The facility informed Resident #1's representative and due to the late hour, they requested that their resident not be transferred to the hospital, until morning. At approximately 9:40AM on 5/15/24, Resident #1 was transported to the hospital via ambulance, where the fracture to the right femur was again confirmed, through x-ray. It was determined that the fracture was inoperable due to a prior knee replacement which took place in October of 2022, along with a previous fracture of the right hip, which took place in November of 2022. Multiple observations throughout the investigation on 5/30/24 and 5/31/24 revealed that above each occupied resident bed was a sign indicating what type of transfer each resident required. Record review of CNA B's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1. The Employee Warning Notice indicated that CNA B declined to write a statement. In the action to be taken section of the Employee Warning Notice, dismissal was checked. CNA B's employment with the facility was terminated on 5/16/24. Record review of CNA C's personnel file revealed an Employee Warning Notice dated 5/16/24. The Employee Warning Notice contained a summary of the inappropriate transfer of Resident #1, CNA C's initial failure to report the subsequent fall. The Employee Warning Notice indicated that CNA C declined to write a statement. In the action to be take section of the Employee Warning Notice, other was checked and the following statement was written: Suspension x 2 weeks. Consequence should incident occur again - additional disciplinary action up to termination. CNA C was immediately suspended for 2 weeks. (continued on next page)

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	675117	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Runningwater Draw Care Center Inc	800 W 13th St Olton, TX 79064

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Multiple staff interviews throughout the investigation on 5/30/24 and 5/31/24 revealed that staff had received extensive training on 5/14/24 and 5/16/24 on abuse and neglect, reporting requirements, appropriate transfers and procedures to follow if a resident falls during a transfer. These interviews revealed that as a result of the incident, competency checks on transfers were initiated and completed for all staff on 5/16/24. Record review of the facility's Safety Precautions, Nursing Services Policy dated December 2009 revealed in part: o Report all unsafe acts or condition to your supervisor as soon as possible. o Pick up debris from the floor. Clean up spills immediately. o Report all injuries, no matter how small. o Follow proper lifting procedures when lifting residents or heavy objects. Record review of the facility's undated Fall Assessment and Management Policy and Procedure, revealed the following: Purpose To ensure fall assessment and management is carried out in a prompt and consistent manner utilizing validated best practice assessment tools. To identify resident fall risk factors. To provide direction for the interdisciplinary team to incorporate and develop best practice fall prevention. To decrease the incidence of falls and fall injuries. Policy All resident's will be assessed for fall risk upon admission. The resident's care plan shall be developed and updated to include individualized and appropriate interventions to prevent falls and reduce the risk of injury based on risk. If a resident has a fall, an assessment shall be undertaken to assess the risk for further falls and determine additional strategies to reduce fall and injury risk. Regardless of risk, fall risk factor and interventions shall be reviewed by the interdisciplinary team at least quarterly. Documentation in resident's health record shall be completed by the care plan manager. All unusual observations and resident's responses will be documented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Procedure If the resident is considered a HIGH RISK, the falls assessment form does not need to be repeated with each fall but does need to be reviewed for possible risk factor changes. A care plan shall be formulated by the interdisciplinary team which includes individualized multi-factorial fall and injury prevention strategies to address risk factors identified from the fall risk form, regardless of the resident's level of risk. Interventions reviewed and updated based on the findings of the reassessments and/or post-fall investigations, including individualized interventions which are re-evaluated and updated to prevent or minimize the risk of falls. Individualized interventions based on causal factors and/or identified risk factors. Date of falls and causal factors identified. Outcomes Individualized interventions identified in the care plan are implemented. Effectiveness of the individualized interventions are monitored and evaluated. Post-fall Assessment, Clinical Review Assess immediate danger to all involved. Call for assistance. Do not move the resident until he/she has been assessed for safety to be moved. Identify all visible injuries and initiate first aid; for example, cover wounds. Assist resident to move using safe handling practices. Notify the physician. Notify family of incident, any new orders, or possible transfer Initiate risk management and follow prompts in Point Click Care for fall prevention. The non-compliance was identified as Past Non-Compliance (PNC). The IJ began on 5/15/24 at approximately 1:30PM and ended on 5/16/24 at 9:53AM. The facility had corrected the non-compliance before the survey began.