STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675133	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Pines Nursing Home	1100 N 4th St Longview, TX 75601

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 - Minimal harm or potential for actual harm 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** 49019 Based on interview and record review, the facility failed to ensure a resident received adequate supervision to prevent accidents for 1 of 5 residents reviewed for accidents (Resident #14). The facility failed to ensure Resident #14 who was identified as high fall risk, confused, unable to be assessed for ability to sit to stand due to medical condition and safety concerns, and required wheelchair was monitored more closely to prevent falls or injury. This failure could place residents at risk for injury or harm. Findings included: Record review of Resident #14's face sheet dated 9/3/2024 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less, subsequent encounter (a type of bleeding near the brain that can happen after a head injury), dementia (general term for impaired ability to remember, think, or make decisions that interferes with doing everyday activities), depression (mood disorder where a person experiences persistent sadness), other seizures (a period of symptoms due to abnormally excessive neuronal activity of the brain), muscle wasting and atrophy (the wasting or thinning of muscle mass due to disuse or nerve problems), weakness, and reduced mobility (difficulties in movement). Record review of Resident #14's Admission MDS dated [DATE] indicated a BIMS score of 1 (severely cognitively impaired). The MDS did not indicate any wandering or behavioral symptoms. The MDS indicated the resident was always incontinent of bowel and bladder and required partial assistance from another person to complete any activities. Record review of Resident #14's baseline care plan dated 9/2/2024 indicated the resident was confused and required substantial to maximal assistance with self-care, bed mobility, sitting to lying, and lying to sitting on the side of the bed. The resident was not assessed for functional ability to sit to stand or walk due to medical condition or safety concerns. The baseline care plan indicated Resident #14 was alert and cognitively impaired. The resident was prescribed one psychotropic medication, Zoloft, and had a history of falls. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #14's care plan initiated on 8/31/2024 and revised on 9/3/2024 indicated the resident was high risk for falls related to confusion. Interventions included to anticipate and meet the needs of the resident, call light within reach, educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs, provide a safe environment with even floors, free from spills and clutter, adequate lighting, reachable call light, bed in low position, handrails on walls, and personal items within reach. Record review of Resident #14's hospital records dated 8/12/2024, Resident #14 was discontinued from levetiracetam 500 mg tablet for seizures. Record review of Resident #14's Fall risk assessment dated [DATE] indicated the resident was always disoriented x3, chairbound, and required assistance with toileting. Resident #14's fall risk score was 13 indicating she was at high risk for falls. Record review of Resident #14's nursing note dated 9/1/2024 at 4:06 PM indicated LVN E was alerted that Resident #14 was on the floor. LVN E went down to assess the resident and found Resident #14 on her right side, head toward the foot of the bed. LVN E proceeded to assess Resident #14 and her range of motion in all extremities. Resident #14 was observed awake and alert to self with confusion. When LVN E asked what happened, Resident #14 said I was trying to go home. Resident #14 had complaints of her head hurting and stated she thought she hit it. During an interview on 9/3/2024 at 1:55 PM, LVN D said she was the admitting nurse for Resident #14. She said she performed an assessment on the day of admission and Resident #14 had advanced dementia and required significant cueing. LVN D said the resident would just look at her food and the staff would have to prompt her to eat. LVN D said the resident was incontinent. LVN D said the fall precautions in place upon admission were keeping bed in low position, call light within reach, and resident received a scoop mattress. LVN D said she thought Resident #14 was moderate to high risk for falling at the time of her assessment. LVN D said she did not observe Resident #14 use her call light due to the family being in the room with resident. LVN D said family would step out and get her if the resident needed anything. LVN D said Resident #14 had a BIM score of 1. She said Resident #14 had a subdural hematoma that was evacuated with incision site derma bonded with no issues or concerns at the site. LVN D said she was not at the facility when Resident #14 fell . During an interview on 9/3/2024 at 2:08 PM, LVN E said she was the nurse caring for Resident #14 the day of her fall. LVN E said she found Resident #14 on the floor closest to the window area and resident's head was at the foot of the bed. LVN E said she picked Resident #14 up and sat her up to assess her. LVN E said Resident #14 had full range of motion and she put her back to bed. LVN E said Resident #14 was complaining of pain 6/10 and then told Emergency Medical Services she could not recall if she was having pain. LVN E said Resident #14 did not have a fall mat next to her bed. LVN E was not sure why Resident #14 did not have a fall mat but stated most places she has worked, would place a fall mat next to a resident's bed on their first day if they were disoriented . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/2024 at 2:15 PM, the ADON said assigning a resident room was based on the need and availability. The ADON said if we see an issue, then we can move a resident around and accommodate their needs. The ADON said the facility assigns new resident's rooms during their standup meeting. The ADON said initially the facility does not place fall mats. She said they determine if the resident tries to get up. The ADON said she did not feel a fall mat would have helped the resident. The ADON said the facility initiated the fall risk for residents on their baseline care plan and kept the call light within reach. The ADON said she was not sure if Resident #14's call light was within reach at the time of her fall. During an interview on 9/3/2024 at 2:29 PM, the DON said she was not at the facility when Resident #14 fell . The DON said Resident #14 fell on Sunday evening and the nurse on the unit notified her of the fall. The DON said Resident #14 was admitted for a traumatic brain injury (TBI) with a diagnosis of seizures due to the TBI. The DON said Resident #14 was not taking any medications for seizures and it was discontinued at the hospital. The DON said once the nurse completes a head-to-toe assessment, then the nurse can assist the resident up if no injuries were evident. The DON said Resident #14 was interacting with her on Friday and remembered her name. The DON said Resident #14's resident representative voiced concern about Resident #14 rolling out of bed and she decided to obtain a scoop mattress. The DON said the facility used fall mats on at risk residents but stated that a fall mat could be a fall risk for some residents. The DON said a marketer who was clinical usually was the one who assigned the resident rooms. The DON said she was not sure if the other marketer who assigned the room for Resident #14 was clinical. The DON said Friday, the resident remembered her name and she did not feel the resident needed to be closer to the nurse's station. During an interview on 9/3/2024 at 3:29 PM, Admission Coordinator G said she had worked for the facility for [AGE] years. She said she was not clinical and did not have credentials. The Admission Coordinator G said the facility did not have any rooms available closer to the nurse's station and made the decision to place the resident across from the DON's office. The outreach marketer said she felt it was a good selection for Resident #14 since people were coming in and out of the area and Resident #14 had visitors. The Admission Coordinator G said she was not responsible for determining if a resident needed a fall mat, it was determined by the nurses after a head-to-toe assessment . During an interview on 9/4/2024 at 1:51 PM, the DON said she expected the nurses and staff to follow the fall policies and procedures. She stated she expected the nurses to complete an assessment. The DON said she would expect the nurses to notify her to determine what was best for the residents. The DON said the facility does not always place high risk residents at the nurse's station. She said they will place the residents across from staff offices or high traffic areas, it was a case-by-case situation. The DON said the facility staff increase their visual checks to ensure the residents were checked on. The DON said rounding was every 2 hours and more frequently on high-risk residents. The DON said the weekend charge nurse had access to her office on Friday. The DON said she felt Resident #14 was placed in a high traffic area near her office was appropriate. The DON said she made decision for the scoop mattress after the resident representative had concerns about Resident #14 rolling out of bed. The DON said the fall mats could cause them to trip, so she was attempting what was safest for the resident for now. The DON said the staff have been in-serviced on fall precautions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/4/2024 at 2:02 PM, the ADM said he was notified that Resident #14 was discharged from the local hospital and being care flighted to another hospital. The ADM felt Resident #14 was appropriately placed in the room in a high traffic area. The ADM said he has seen several high acuity residents in the room Resident #14 was placed. The ADM said he did not like fall mats because they were thick, and he said he found them counterproductive and was not a fan. The ADM said he felt starting out with the scoop mattress provided the higher level of protection. The ADM said Resident #14 was just admitted and was not a frequent faller according to his communication with the DON regarding Resident #14's history. The ADM said he did not know if Resident #14 fell in her home resulting in her subdural hemorrhage and thought the hematoma was an ongoing issue. The ADM said the facility provided progressive interventions and hopefully it showed improvement in falls . Record review of facility's policy revised on 8/2020 titled Fall evaluation and prevention indicated the purpose was to ensure that the resident's environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance to prevent accidents. The facility will evaluate resident for their fall risk and develop interventions for prevention. Upon admission, the nursing staff or interdisciplinary team should determine if a resident is at risk for falls and developing appropriate interventions based on the evaluation. The staff should not utilize a restraint to prevent falls unless they receive written documentation to support the use of the restraint. The care plan should only specify a few interventions at a time so the staff can determine what intervention is not successful and needs to be changed. Procedure: A resident should be evaluated for their fall risk On admission .readmission .following any change in status that may affect balance, mobility, or safety following a fall .quarterly .Risk factors associated with a fall . gait and balance disorder .muscular weakness . dizziness or vertigo . confusion . stroke . Parkinson's disease . vision and hearing impairment .seizure disorder .depression .previous falls . certain medication classes such as antipsychotics, sedatives, tricyclic antidepressants, anxiolytics, certain antihypertensives including diuretics that cause or exacerbate orthostatic hypotension, the use of 5 or more different medications. Intervention suggestions for fall prevention: orient resident to room on admission and re-admission . demonstrate use of nurse call system and ensure call cord within reach at all times .place assistive devices within reach .evaluate medications .evaluate socks and shoes to determine if they are skin resistant, position the bed so that the exit is toward the resident strong side .refer to PT or OT. Following a fall: Evaluate the resident promptly to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition .Evaluate the environment where the fall occurred, noting any factors that may have contributed to the fall .Ask the resident what happened prior to the fall .Complete the accident and incident report and notify physician and responsible party .If the fall was unwitnessed, initiate the investigation including witness statements from staff and residents .