STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 10 residents (Resident #1) reviewed for notification of changes. The facility failed to ensure Resident #1's physician was notified when the resident's oxygen was at 77% on room air on 03/09/24. The noncompliance was identified as PNC. The noncompliance began on 03/09/24 and ended on 03/10/24. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for delay in treatment and decreased quality of life. Findings include: Record review of Resident #1's face sheet, dated 03/22/24, reflected a [AGE] year old female who was admitted on [DATE]. Resident #1 had diagnoses which included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), cognitive communication deficit (difficulty with thinking and how someone uses language), need for assistance with personal care, muscle wasting and atrophy (decrease in size and wasting of muscle tissue), rhabdomyolysis (rare muscle injury where muscles break down), abnormalities of gait and mobility (weakness of the hip and lower extremity muscles commonly cause gait disturbances), lack of coordination, reduced mobility, and a history of falling. Record review of Resident #1's quarterly MDS assessment, dated 01/05/24, reflected she was sometimes able to make herself understood, understood others, had severe cognitive impairment (BIMS score of 7), had impaired range of motion on one upper side extremity and impaired ROM of both lower extremities, utilized a wheelchair for mobility, and required assistance to transfer to and from a bed or wheelchair. Record review of Resident #1's physician orders, dated 11/28/23, reflected: May use Oxygen at 2 LPM for SOB, may titrate to keep SPO2 >90%. Every 8 hours as needed for SOB. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan, dated 01/26/22, reflected Resident #1 had a respiratory infection as evidenced by positive Covid-19 (an infectious disease caused by the SARS-CoV-2 virus) testing or respiratory infection, potential Covid-19 positive due to presence of signs and symptoms. Interventions included administer medications and oxygen as needed. Record review of progress note, dated 03/09/24 at 11:45 p.m., completed by LVN C, reflected CNA A reported Resident #1 does not look right and something was wrong with her. Resident #1's VS: 97.9 T, 102/60 BP, 48 P, 12 R, O2 SATS 77%. Resident #1's skin was pale, warm and dry. Neuros were WNL. Resident #1 denied pain. Lungs were clear to CTA. PRN oxygen applied via nasal cannula at 2L. Will continue to monitor. Record review of progress note, dated 03/10/24 at 1:20 a.m., completed by LVN C, reflected when LVN C applied the BP cuff to Resident #1's wrist, Resident #1 said ow. LVN C looked at Resident #1's hand and wrist and asked if she as in pain. Resident #1 giggled and replied no. LVN C asked Resident #1 to raise her arms and Resident #1 was able to raise both arms with no sign or symptom of pain and no complaint of pain. LVN C asked Resident #1 to smile and no facial drooping was noted. LVN C discussed Resident #1's low O2 and pale coloring with 400 hall nurse who stated that pale coloring was normal for Resident #1 and low O2 was not new either as she had an order for PRN O2. DON was notified. Will continue to monitor. Record review of progress note, dated 03/10/24 at 6:00 a.m., completed by LVN C, reflected Resident #1 was resting in bed. No sign or symptoms of SOB, pain, or discomfort. Resident #1 continued to deny SOB and pain. SpO2 at 92% on 2L via nasal cannula. Reported low SpO2 to oncoming LVN. Record review of progress note, dated 03/10/24 at 1:34 p.m. by LVN D, indicated CNA E reported Resident did not urinate for the entire shift but did have a BM. CNA E reported Resident #1 complained of pain to her left hip when she was rolled on to her left side during incontinent care. Left hip was assessed and swelling noted. Resident #1 was able to move her left leg. And when asked where she was hurting, she replied my arm STAT x-ray that had been ordered at 8:00 a.m. had not arrived at facility. Resident transferred to ER for evaluation. Record review of progress note, dated 03/10/24 at 2:04 p.m., completed by LVN D, reflected Resident #1 was transferred to the hospital at 2:00 p.m. related to pain and discoloration to left upper arm, swelling and pain to left hip, and decreased urine output. During an interview on 03/22/24 at 2:20 p.m., the DON said LVN C sent her a text after midnight on 03/10/24 regarding Resident #1's low O2 SATS, but she did not see it until after she woke up on 03/10/24 at approximately 6:00 a.m. She said she called the facility after she saw the message from LVN C and Resident #1's O2 SATS had improved. She said if she was called she would have directed LVN C to call the physician to obtain orders or sent transferred Resident #1 to the hospital for evaluation and then notified the physician. She said Resident #1 could have had a continued decline in health without adequate medical intervention. During an interview on 03/22/24 at 3:00 p.m., NP L said she or MD F should have been notified of Resident #1's low O2. She said although Resident #1's O2 SATS had increased throughout the night on 03/10/23, she would have sent Resident #1 to the hospital for assessment. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/28/24 at 10:58 a.m., LVN C said on 03/09/24, Resident #1 said ow when she was taking her BP. She said she asked Resident #1 if she was in pain and Resident #1 giggled. She said the aide said she did not look right and her O2 was at 77%. She said she sent a text message to the DON, but she did not call the DON, the NP, or the MD. She said Resident #1 had a PRN order for O2 and Resident #1's O2 SATS improved with the O2. She said Resident #1's O2 SATS came up gradually throughout the night. She said Resident #1's O2 was up to 92% by 5:00 a.m. She said she was trained previous to 03/09/24 on physician notification and was retrained on 03/10/24 to notify the physician of resident change in status and it included low O2 SATS. She said she did not notify the physician because she talked with the other nurse and Resident #1 had a PRN order for O2 via nasal cannula PRN. During an interview on 04/01/24 at 10:13 a.m., MD F said he normally received calls when a resident's O2 SATS decreased. He said a resident could be hypoxic (a state in which oxygen is not available in sufficient amounts at the tissue level). He said staff should have reported Resident #1's low O2 SATS. He said he would have sent her to the hospital for evaluation. Interviews with 5 LVN's (LVN M and LVN O 2:00 p.m. - 10:00 p.m. and prn all shifts, LVN L and LVN N 6:00 a.m.- 2:00 p.m. and prn shifts, LVN O 10:00 p.m.-6:00 a.m. and prn shifts) said they received training prior to the incident and after the incident on 03/10/24 from the ADON regarding physician notification of resident change of condition. The nursing staff verbalized understanding of the trainings and were able to give examples of when (any change of resident condition, uncontrolled or unexplained pain, or low O2 SATS) and how to notify the physician (by phone call and physician acknowledged). Record review of the facility's policy, dated 2003 (revised 03/11/13), Notifying the Physician of Change in Status reflected The nurse shall not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record. Interview with the DON on 04/03/23 at 2:20 p.m. indicated she monitored all 24 hour reports daily Monday through Friday to ensure physician notification. Record review of 9 resident's clinical charts (Resident #s 2,3,4,5,6,7,8, 9, and 10) indicated no concerns. Record review of in-service training, dated 03/10/24, reflected all facility nurse staff were re-trained on Notifying the Physician of Change of Status. The noncompliance was identified as PNC. The noncompliance began on 03/09/24 and ended on 03/10/24. 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 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** 25115 Based on interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 10 residents (Resident #1) reviewed for accidents and supervision. 1. The facility failed to ensure Resident #1 did not sustain injuries of unknown origin. On 03/10/24 Resident #1 was diagnosed with a comminuted (broken in two places) intertrochanteric left femur (thigh bone) fracture with varus angulation, comminuted intertrochanteric right femur fracture with varus (inwards) angulation, and anteriorly displaced distal fracture fragment of the right femoral fracture, and an acute angulated displaced fracture of the left proximal humeral diaphysis (shaft). 2. The facility failed to ensure CNA A transferred Resident #1 with a gait belt on 03/09/24 per facility protocol. An Immediate Jeopardy (IJ) situation was identified on 04/03/24. While the IJ was removed on 04/04/24, the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for falls resulting in injury, pain, and hospitalization . Findings include: Record review of Resident #1's face sheet, dated 03/22/24, reflected a [AGE] year old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), cognitive communication deficit (difficulty with thinking and how someone uses language), need for assistance with personal care, muscle wasting and atrophy (decrease in size and wasting of muscle tissue), rhabdomyolysis (rare muscle injury where muscles break down), abnormalities of gait and mobility (weakness of the hip and lower extremity muscles commonly cause gait disturbances), lack of coordination, reduced mobility and a history of falling. Record review of Resident #1's assessment, dated 01/05/24, reflected she was sometimes able to make herself understood, understood others, had severe cognitive impairment (BIMS score of 7), had impaired range of motion on one upper side extremity and impaired ROM of both lower extremities, utilized a wheelchair for mobility, and required assistance to transfer to and from a bed or wheelchair. Record review of Resident #1's care plan, dated 10/16/21, reflected she was at risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs and vision problems. Interventions included one staff to assist with transfers. (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 Resident #1's care plan, dated 10/16/21, reflected Resident #1 had an ADL self-care performance deficit related to activity intolerance, confusion, dementia, fatigue, impaired balance and limited mobility. Interventions included one staff for transfer assistance. Record review of Resident #1's Kardex (electronic care record), provided by the facility on 04/04/24, reflected Resident #1 required one staff assist with transfers. Record review of progress note, dated 03/09/24 at 5:00 p.m., completed by LVN B, indicated CNA A notified LVN B that when she transferred Resident #1 to the bed from the wheelchair, Resident #1 complained of pain to RLE. ROM WNL to all extremities and no signs of symptoms of pain or discomfort. Resident #1 refused Tylenol. Record review of progress note, dated 03/09/24 at 11:45 p.m., completed by LVN C, reflected a can A reported Resident #1 does not look right and something was wrong with her. Resident #1's skin was pale, warm and dry. Neuros WNL. Resident denied pain. Lungs were clear to CTA. Will continue to monitor. Record review of progress note, dated 03/10/24 at 1:20 a.m., completed by LVN C, reflected when LVN C applied the BP cuff to Resident #1's wrist , Resident #1 said ow. LVN C looked at Resident #1's hand and wrist and asked if she as in pain. Resident #1 giggled and replied no. LVN C asked Resident #1 to raise her arms and Resident #1 was able to raise both arms with no sign or symptom of pain and no complaint of plain. Asked Resident #1 to smile and no facial drooping noted. DON notified. Will continue to monitor. Record review of progress note, dated 03/10/24 at 6:00 a.m., completed by LVN C, reflected Resident #1 was resting in bed. No sign or symptoms of SOB, pain or discomfort. Resident continues to deny SOB and pain. Record review of progress note, dated 03/10/24 at 1:34 p.m., by LVN D reflected CNA E reported Resident did not urinate for the entire shift but did have a BM. CNA E reported Resident #1 complained of pain to her left hip when she was rolled on to her left side during incontinent care. Left hip was assessed and swelling noted. Resident #1 was able to move her left leg. And when asked where she was hurting she replied my arm STAT x-ray that had been ordered at 8:00 a.m. had not arrived at facility. Resident transferred to ER for evaluation. Record review of progress note, dated 03/10/24 at 2:04 p.m., completed by LVN D, reflected Resident #1 was transferred to the hospital at 2:00 p.m. related to pain and discoloration to left upper arm, swelling and pain to left hip and decreased urine output. (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 hospital records, dated 03/10/24, reflected Comminuted intertrochanteric left femur (thigh bone) fracture with varus angulation, comminuted intertrochanteric right femur fracture with varus angulation, anteriorly displaced distal fracture fragment of the right femoral fracture, and acute angulated displace fracture of the proximal humeral diaphysis (shaft) . Bruising noted to left collar bone, left neck, left inner upper arm, left elbow, right outer mid-calf, right hand, and left hand. Patient responsive to pain only. Dried blood noted to fingernails and gown with no source of active bleeding . 4:15 p.m. incon(tinent) care performed . crepitus (a popping, clicking or crackling sound in a joint) felt to right hip-patient alert-yelling 'I want to go home' . 4:40 p.m. patient yelling out-'I want to go home .what are you doping to me . Please don't hurt me' denied pain at this time. During an interview on 03/22/24 at 10:52 a.m., LVN D said she worked on Saturday, 03/09/24, until 2:30 p.m. She said Resident #1 was up in her wheelchair for the most part and had no complaints of pain on that day. She said Resident #1 was her normal self. Resident #1 would usually be up in her wheelchair. She said Resident #1 required assist of one staff for transfers from her wheelchair to bed and bed to wheelchair. She said Resident #1 could not stand on her own. She said she was not aware of any recent falls for Resident #1. She said if Resident #1 had fallen she would not be able to get herself up and in her bed without assistance. She said Resident #1 stayed in bed on 03/10/24 due to waiting for STAT x-ray for the pain in her arm. She said Resident #1 complained of pain to her left arm. She said Resident #1 complained of pain when she was rolled on to her left side during incontinent care. She said CNA G reported the complaint of pain. She said STAT x-ray had not shown since the morning request and due to the new complaint of pain, Resident #1 was transferred to the hospital for evaluation. She said the information for resident care was in the Kardex system. She said if staff did not follow the Kardex for care needs then residents could get seriously injured. She said she was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. During an interview on 03/22/24 at 12:53 p.m., the DON said she went to the hospital on 03/10/24 and did not see any bruises on Resident #1's face, neck, color bones or limbs. She said she trained staff on dementia and pain. She said Resident #1 would not have been able to get up from a fall without assist and she was not aware of any recent falls for Resident #1. She said Resident #1 required the assist of 1 staff for transfer from her wheelchair to the bed or the bed to wheelchair. She said if staff did not follow the Kardex for care needs then residents could get seriously injured. She said she was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. During an interview on 03/22/22 at 2:32 p.m., LVN B said CNA A came and got her from the nurse station at approximately 7:00 p.m. on 03/09/24. She said CNA A said she transferred Resident #1 and Resident #1 winced. She said she assessed Resident #1 and asked Resident #1 if she was hurting. She said Resident #1 said she was not hurting. She said there was no redness or bruising. She said she moved all of Resident #1's limbs as she was in a lying position on her bed and Resident #1 said she had no pain. She said she offered Resident #1 a pain medication and Resident #1 declined the pain medication. She said she came back to work at 2:00 p.m. on 03/10/24 and Resident #1 was in the process of being transferred to the hospital. She said if staff did not follow the Kardex for care needs then residents could get seriously injured. She said she was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. She said she was not aware of any falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/28/24 at 10:13 a.m., CNA I said he started his shift at 10:00 p.m. on 03/09/24. He said Resident #1 was in bed. He said he got report from CNA A that Resident #1 was hurting too bad to change and she was screaming and crying. He said he checked on Resident #1 and Resident #1 said she was hurting. He said Resident #1's color was off. He said LVN C brought her some pain medication. He said then it seem like Resident #1 was having dry-heaving and choking, then gasping for air followed by more heaving. He said LVN C looked Resident #1 over and he looked her over too as they were looking for mottling. He said LVN C and he checked on Resident #1 throughout the shift. She said her left arm hurt. He said Resident #1 assisted with rolling over during care, but her hip seemed loose and it had less control than her right hip. He said he never saw Resident #1 in that physical condition before. He said she was complaint with care and was not aggressive. He said she required assist of one staff for transfers from her wheelchair and bed. He said the gait belt was required for all transfers. He said if staff did not follow the Kardex for care needs then residents could get seriously injured. He said he was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. He said she was not aware of any falls. During an interview on 03/28/24 at 10:58 a.m., LVN C said Resident #1 said ow when she was taking her BP. She said she asked Resident #1 if she was in pain and Resident #1 giggled. She said the aide said she did not look right. She said Resident #1's neuro's were within normal limits, she lifted both of her hands equally and wiggled her toes and feet. She said she did not do full ROM and lift her legs or wiggle her hips because it was not usually done for someone who was in a wheelchair. She said if staff did not follow the Kardex for care needs then residents could get seriously injured. She said she was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. She said she was not aware of any falls. During an interview on 03/28/24 at 3:41 p.m., CNA A said on 03/09/24, Resident #1 was at the nurse's station after her supper meal. She said Resident #1 wanted to go to her bed after the supper meal. She said she changed Resident #1's shirt while she was seated in her wheelchair. She said she transferred Resident #1 from her wheelchair to her bed. She said Resident #1 put her arms around her (CNA A) neck and shoulder area and she (CNA A) put her arms under Resident #1's arms around her upper back area and lifted her and put her on the bed. She said she transferred Resident #1 how she normally transferred her. She said she did not need the gait belt because Resident #1 was not heavy. She said she sat Resident #1 on the bed and then lifted her feet and legs and turned her so she was fully on the bed. She said Resident #1 laid down and she (CNA A) took off Resident #1's pants. She said Resident #1 was groaning. She said she asked Resident #1 if she was hurting and she said Resident #1 said she was hurting all over. She said Resident #1 never complained of hurting before with previous transfers. She said she told LVN B about Resident #1's complaint of pain. She said LVN B came and moved all of Resident #1's limbs. She said Resident #1 declined any pain medication. She said Resident #1 said she could not move her arm but lifted her right arm and not her left arm. She said she was not aware of any bruises. She said she did not usually work with Resident #1. She said she was trained to use a gait belt for transfers. She said if staff did not follow the Kardex for care needs then residents could get seriously injured. She said she was not aware of how Resident #1 could have sustained a fracture to her left arm or two bilateral femur fractures. During an interview on 04/01/24 at 10:13 a.m., MD F said Resident #1's fractured arm and bilateral femurs could have occurred due to a fall and being picked up or transferred. He said there was no way to determine how the fractures occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/01/24 at 11:27 a.m., CNA G said Resident #1 required extensive assist of one staff for transfers. She said all transfers were done with a gait belt. She said she transferred Resident #1 from her bed to the wheelchair for breakfast, then back to her bed after breakfast for incontinent care then back to her wheelchair. She said Resident #1 ate lunch then she transferred her to her to bed for incontinent care and afternoon reset. She said she transferred Resident #1 to her wheelchair for the supper meal. She said after the supper meal, CNA A transferred Resident #1 to bed. She said CNA A mentioned Resident #1 was in pain and the nurse was informed. She said when she returned to work on 03/10/24, Resident #1 said she was in pain all over. She said Resident #1 complained of pain during care. She said she completed the care, and she reported Resident #1's pain to the nurse. She said she asked Resident #1 if she wanted to get up for breakfast and Resident #1 said she did but Resident #1 complained of pain and stayed in bed. She said she and CNA H completed peri-care after breakfast and Resident #1 complained of pain. She said she completed the care and reported Resident #1's pain to the nurses. She said the nurse came to the room and Resident #1 was later sent out to the hospital. She said Resident #1's left hip looked like there was something wrong, a little swollen and loose. She said Resident #1 was always compliant with care and not aggressive. She said she was not aware of any falls. She said Resident #1 would not be able to lift herself up from the floor after a fall. During an interview on 04/01/24 at 11:55 a.m., CNA H said she assisted CNA G to complete peri-care on Resident #1. She said Resident #1 complained of pain when being turned onto her hips during care. She said the nurse was informed of the pain. She said Resident #1 was usually complaint with care and not aggressive. She said she was not aware of any falls for Resident #1. She said Resident #1 required transfer assist of one staff. She said staff was required to use a gait belt with all transfers. During an interview on 04/03/24 at 1:24 p.m., PTA J said she started re-training staff on transfers and gait belts on 03/11/24. She said she trained CNA A on 04/02/24. She said she still had some staff to retrain. PTA J said staff were supposed to use gait belts for all pivot transfers. Record review of CNA A's competency check off for Assisting Residents to Transfer to Chair or Wheelchair, dated 11/07/23 and completed by PTA A, reflected .show the resident the gait belt and explain its use as a safety device. Apply the gait belt over the resident's clothing around the waist and check the fit by inserting your fingers under it, stand in front of the resident with your knees bent, feet apart, and back straight. Grasp the gait belt with an under-hand grip and move the resident forward so his or her feet are flat on the floor. Lean forward and instruct the resident to place his or her hands on your shoulders. Do not let the resident put his or her arms around your neck. Place your hands on either side of the gait belt, and on prearranged signal, gradually assist the resident up into a standing position, supporting the knees and feet with your legs and feet as appropriate. This was determined to be an Immediate Jeopardy (IJ) on 04/03/24 at 12:23 p.m. The Administrator was provided with the IJ template on 04/03/24 at 12:23 p.m. The following Plan of Removal submitted by the facility was accepted on 04/04/24 at 9:35 a.m.: As of 4/3/24, CNA A was in-serviced 1:1 by the DON on the following: All other nursing staff were in-serviced on the same topics by the DON/ADON/Director of Rehab. Completion date will 4/4/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675152	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dogwood Trails Manor	647 US Hwy 190 W Woodville, TX 75979

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Following the Kardex in Point Click Care for all transfer status and assistance required with return demonstration from staff. -Gait belt transfers with return demonstration. -Abuse and Neglect (Improper transfers) -Fall Prevention Policy will be completed 1:1 with CNA A as of 4/4/24 by the Regional Compliance Nurse. This in-service will include reporting to the charge nurse immediately if a resident suffers a fall, has an accident, or is found on the floor. If the charge nurse is not available, staff will report to the DON immediately. Staff will not assist a resident off the floor until a charge nurse has been notified and assessed the resident. -As of 4/3/24 all residents in the facility received head to toe assessment by the DON/ADON/Tx Nurse for any injuries and/or fractures. No additional issues were found. -On 4/3/24, all residents in the facility were assessed and evaluated for transfer assistance by the DON/ADON and Director of Rehab. -On 4/3/24, all resident care plans were reviewed for accuracy of transfer status and assistance by DON and ADON. No issues were identified. -On 4/3/24 the Facility initiated our second round of gait belt training and check offs with return demonstration. All nursing staff will be checked off again prior to the start of their next shift. Training and checks will be completed by DON/ADON/and Director of Rehab. -The medical director was notified of the immediate jeopardy by the administrator on 4/3/24. -Ad hoc QAPI was held with the Medical Director and facility interdisciplinary team on 4/3/24 to discuss the immediate jeopardy and subsequent plan of removal. In-services: The Administrator, DON, and ADON were in-serviced 1:1 on the following topics below on 4/3/24 by the ADO/Regional Compliance Nurse. The DON and ADON then in-serviced all nursing staff on the following topics below as of 4/3/24. All staff not present will not be allowed to assume their duties until in-serviced. All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to start of their assignment. -Abuse and neglect policy to include (Improper transfers) -Gait belt transfers with return demonstration. -How to use the Kardex in PCC to determine the transfer status of a resident with return demonstration. (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	-Fall Prevention Policy will all nursing staff as of 4/4/24 by the Regional Compliance Nurse/ADON. This in-service will include reporting to the charge nurse immediately if a resident suffers a fall, has an accident, or is found on the floor. If the charge nurse is not available, staff will report to the DON immediately. Staff will not assist a resident off the floor until a charge nurse has been notified and assessed the resident. Monitoring of the plan of removal included the following: Observations, interviews and record reviews were conducted on 04/04/23 from 1:00 p.m. through 2:55 p.m. and included 5 alert residents, nurses which included 1 RN (RN R weekend supervisor), 7 LVNs (LVN D 6:00 a.m. - 2:00 p.m., LVN M and LVN O 2:00 p.m. - 10:00 p.m. and prn all shifts, LVN L and LVN N 6:00 a.m.-2:00 p.m. and prn shifts, LVN O 10:00 p.m.-6:00 a.m. and prn shifts LVN S 2:00 p.m. -10:00 p.m., and 6 CNAs (CNA G, H, I, P, Q, S - who work all shifts), the ADON and the Administrator. Observations on 04/04/24 of gait belt transfers completed by CNA P and CNA Q. They were able to transfer Resident #7 and #10 per the facility check off list. Staff were able to demonstrate the use of a gait belt and transfer for 2 residents. Staff provided appropriate resident supervision and redirection. There were no observed concerns. During interviews staff were able to identify the Abuse Coordinator as the administrator. Staff indicated they were to report allegations of abuse and neglect immediately to the charge nurse or administrator and were able to give example of physical, verbal, sexual abuse and immediate intervention procedures. They were to report all falls and residents found on the floor to the charge nurse. During interviews staff were able to identify residents' the care plans, the Kardex system and how to find level of resident care, fall risks and prevention strategies, and who the abuse coordinator was. During an interview on 04/04/24 at 2:38 p.m., the Administrator said the audit of all residents' care plans and Kardex revealed no issues or concerns. She said all staff were trained upon hire and provided a gait belt for use with transfers. Interviews with five residents on 04/04/24 from 1:00 p.m. through 2:55 p.m. (Resident #s 5,6,7, 8, and 10) indicated they were not afraid during care or had complaints of their care. Interviews with staff revealed staff were able to discuss the required level of staff assistance for ADLs per resident. Staff were able to demonstrate the use of the Kardex system for resident care needs. Record review of the Kardex for 9 residents (Resident #s 2,3,4,5,6,7,8,9, and 10) to ensure they matched with the resident's level of assistance required. The resident care plans matched the Kardex. Record review of a facility audit for all residents indicated no issues or concerns and all care plans matched levels of care in the Kardex. Record review of facility in-service indicated facility staff were in-serviced on abuse and neglect by the DON and ADON. The training was completed on 03/29/24 and 04/03/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility in-service indicated facility staff were in-serviced 04/03/24 and 04/04/24 on Preventative Strategies to Reduce Fall Risk and reporting to charge nurse immediately if a resident is found on the floor. The training was completed by the ADON and RN K. Record review of facility in-service indicated the Administrator, the DON, and the ADON were retrained on abuse and neglect and improper transfers, gait belt transfers, and the Kardex (how to use with return demonstration), on 04/03/24 by PTA J. Record review of facility in-service indicated all nursing staff (LVNs and CNAs) were retrained by PTA J on 04/03/24 related to transfers/Hoyer lifts, and gait belts with return demonstration. Record review of facility in-service indicated CNA A was retrained on how to use the Abuse and Neglect (Improper Transfers), Kardex and transfers with gait belt with return demonstration on 4/3/24 by the DON. Record review of facility in-service indicated CNA A was retrained by PTA J and completed transfer proficiency check off on 04/03/24. Record review of facility in-service indicated CNA A was re-trained on fall prevention strategies on 04/04/24 by RN K. Record review of facility in-service indicated staff who were unavailable and not in-serviced were on a list to receive training prior to their next scheduled shift. The Administrator was informed the Immediate Jeopardy was removed on 04/04/24 at 2:59 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.