STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675234	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake Nursing Center	603 E Plantation Rd Clute, TX 77531

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 0657

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46561

Based on observation, interview, and record review the facility failed to review and revise the person-centered care planning for one (Resident #2) of eight residents reviewed for care plan revision in that:

1. Resident #2's care plan was not updated when he had a decline in health and did not have the strength to sit upright.

2. Resident #2 was placed into his wheelchair and left unattenededunattended after a decline in his health caused him unsteady trunk balance and support. He fell out of the wheelchair, hit his face, and was transferred to the emergency room .

An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 032:50 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal.

This failure could place residents at risk for decreased quality of care and quality of life.

Findings included:

Record review of Resident #2's face sheet revealed an eighty-year-old man admitted on [DATE]. His admitting diagnoses were atherosclerosis of arteries (build up in arteries) in right and left leg with ulceration of foot, contractures of muscle in right and left lower leg, pain in right and left knee, and stiffness of unspecified joint. Resident #2 was also on hospice.

Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) Section C - Cognitive Patterns dated [DATE] revealed a score of ,d+[DATE], severely impaired.

Record review of Resident #2's MDS Section G- Functional Abilities and Goals dated [DATE] revealed that Resident #2 was totally dependent for bed mobility and transfers. He also was categorized as a two-person physical assist.

(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: 675234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024

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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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #2's care plan (revised [DATE]) revealed that he was at risk for falls related to gait/balance problems, paralysis/contracture, vision/hearing problems and cognitive loss. Interventions prior to fall listed to encourage resident to lay in center of bed (dated [DATE]), anticipate and meet needs (revised [DATE]), and to monitor in wheelchair for safety (post fall, [DATE]). Care plan also stated that he was placed on hospice on [DATE] and interventions included to adjust provision of ADLS to compensate for changing abilities. Record review of Resident #2's progress note dated on [DATE] at 05:30 pm revealed that LVN E discussed with a family member that Resident #2 had been refusing to eat, take his medication, and there had been a decline is his ADLs. The option of hospice was suggested to the family. Record review of Resident #2's progress note dated on [DATE] at 11:26 am, LVN E spoke with another member of the family and expressed her concern for Resident #2's decline due to his low food and fluid intake. Family member stated that they had decided to move forward with hospice and they were in the process of choosing a company. Record review of Resident #2's progress note dated on [DATE] at 10:56 am, LVN E documented that a hospice company was selected. Record review of Resident #2's progress note dated on [DATE] at 11:55 am, RN B documented the resident had his first hospice visit and received comfort supplies. Record review of Resident #2's progress note dated on [DATE] at 5:06 pm.m., WCN documented that the resident had an unwitnessed fall and was found on the floor with a laceration to his right eyebrow. Record review of Resident #2's progress note dated on[DATE] at 9:18 pm.m., WCN documented that the resident returned to the facility in a wheelchair by transport vehicle. In an interview on [DATE] at 2:48 pm.m., CNA E stated that Resident #2 was a total care resident and was currently on hospice. She said that he used to get up in his wheelchair and sit in the dining room but ever since he was placed on hospice, they no longer did a lot with him. She stated that she did not work the day of his fall on [DATE] but she was confused on why the staff got him out of bed. She explained that Resident #2 no longer had balance and he could not sit in a wheelchair. In an observation on [DATE] at 4:03 pm.m., Resident #2 was in bed asleep. His bed was in a low position and side rails were in place as well as a fall mat. A wheelchair was folded against the wall and displayed that it was from the hospice company. In an interview on [DATE] at 4:05 pmp.m. with WCN, she stated that she had worked at the facility for 1 year but she had never seen Resident #2 out of bed. She explained that he was constantly in pain, with 2 pressure ulcers and 4 arterial wounds. When he returned to the facility after his fall, he had steristrips covering the laceration on his forehead that healed in a week or so. She stated that he did have a wheelchair but believed the wheelchair had been provided from hospice. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 E Plantation Rd Clute, TX 77531	

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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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 12:07 pm.m., with CNA C, she stated that the Restorative aide was in Resident #2's room and she asked her for help to get him out of bed and into his wheelchair on [DATE]. She explained that Resident #2 had stopped getting up a month prior to this incident and if they did, it would be dependent on how he felt. She stated that after she helped the Restorative Aid, she stated that the aide did not recline his chair and she guessed that he fell forward and had a gash above his right eye. She did not see the fall but stated that he was sent out using emergency services to make sure he was alright. In an interview on [DATE] at 12:24 pm.m., with the Restorative Aide, she stated that on [DATE], she walked past Resident #2's room and asked the resident if he wanted to get out of bed, in which he replied, yea baby. With the help of CNA C, she transferred him into the wheelchair and set his bedside table up in front of him. She asked him did he want coffee, and she left the room along with CNA C to grab some coffee. When the Restorative Aide returned to the room with the coffee, she set it on his table, asked if he was ok, and left out the room. Several minutes later, she heard staff screaming and when she came back to the room, she saw the bedside table knocked over on the floor, Resident #2 had fallen out of the wheelchair onto the floor, and his head was laid against the leg of the table. After, an in-service was done that covered from the RD that if Resident #2 was in a sitting position, his wheelchair needed to be reclined back. She explained that she didn't originally recline his wheelchair back because he was drinking coffee and she was trying to align his body. In an interview on [DATE] at 12:46 pm.m., with the DON, she stated that Resident #2 had been getting worst in the past few months and he was placed on hospice 2 months prior. She stated that he had passed away in his sleep on [DATE] around 2:30 am. She stated that he fell out of his wheelchair on [DATE], but she was not there. She stated that she thought he was too weak and suggested that maybe he had tried to grab something from his bedside table. Resident #2 did hit his head, but his results came back negative. She denied that he should have been sitting a certain way. She stated that the staff had stopped getting him out of bed as frequently because she was worried about him sitting in his wheelchair for extended periods of time. An attempted call was made on [DATE] at 1:28 pm.m., to the NP. A voicemail was left requesting a call back. An attempted call was made on [DATE] at 1:26 pm.m., to the hospice nurse. A voicemail was left requesting a call back. In an interview on [DATE] at 1:48 p.m., with the RD, she sated that Resident #2 had a chair from hospice and it did recline. She could tell that he hit his head on the base of the table and said that from then on, she instructed all aides to recline his chair because he could not recover his strength to bring his body back after he reached for something. She stated that he had not been out of his wheelchair in a least a week or so, but he used to be able to sit in a normal wheelchair. She stated that he did not have the trunk stability to bring himself back upright in a wheelchair so she made the recommendation after the fall to have him reclined when he sat. The Administrator was given the IJ template and was notified of the IJ on [DATE] at 2:50 p.m. and a POR was requested. On [DATE] at 9:17 am.m., the POR was accepted. It was documented as follows: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 E Plantation Rd Clute, TX 77531	

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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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Re: Plan of Removal of Immediate Jeopardy The following is a plan of removal, which was immediately implemented at XXX, to remedy the Immediate Jeopardy which was imposed [DATE] at approximately 3:00 pmPM. The notification of Immediate Jeopardy states as follows: F657 All items listed will be completed by 5:00 pmPM on [DATE] with continued follow-up for scheduled staff. 1. Resident #2 a hospice resident with a life expectancy of less than 6m is deceased . 2. Administrator/DON initiated an in-service regarding policy and procedure for care plans with all licensed staff on [DATE]. The regional director of operations and the Regional clinical director reviewed the care plan policy prior to in-service and determined the policy did not need changes. A post-test will be performed with staff over information in-serviced on by administration, and a score of 100% must be achieved. If less than 100%, staff will be reeducated and retest until 100% is achieved. 3. The corporate MDS nurse and the facility MDS nurse initiated a review of all care plans for current fall interventions in place to ensure its on the care plan and a viable intervention. This action started on [DATE]. All fall interventions on the care plan are technologically added to the Kardex. 4. The Administrator and DON initiated an in-service on [DATE] with all direct care staff regarding care plan electronic medical record review for the care plan tab and Kardex review in point of care (POC) a module within the electronic medical record point click care (PCC) 5. An in-service was initiated with direct care staff regarding the change of condition policy and communication of interventions on [DATE]. The policy was reviewed by the regional director and regional clinical director and no changes are warranted. 6. A review of the last 90 days of fall incidents will be performed starting [DATE] by the DON and ADON. Every intervention listed will be reviewed for care plan occurrence. 7. Administrator/DON initiated a 1:1 Inservice with the MDS/Care plan nurse regarding care planning current interventions ordered. 8. The DON or designee will review fall incidents during the stand up meeting for the previous 24 hours on Tuesday-Friday and the previous 72 hours on Monday to ensure all fall incidents interventions have been placed on the care plan. Any negative findings will be immediately forwarded to the QAPI committee for warranted action plan changes. 9. Administrator and DON were in-serviced on [DATE] by Regional Director of Clinical Services on all the policy mentioned above, and to notify regional/corporate staff of ALL falls/incidents care plans, and are to notify regional/corporate staff of any discrepancies. Regional/corporate staff will follow-up on each fall/incident in question and direct with appropriate interventions. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	If staff are unable to attend any of the in-services, they will be required to complete the in-service before starting their assigned shift. Any agency will be in-serviced prior to the beginning of their shift. Any new hires will be in-serviced on hire, prior to working a shift. The Medical Director was made aware of the Immediate Jeopardy [DATE] at 3:21 pmPM and has been involved in developing the Plan of Removal. These conversations are considered part of the QA process. A QAPI meeting was held on [DATE] with attendance of Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Regional Director of Clinical Services, and Regional Director of Operations. This plan was initially implemented [DATE] and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is [DATE] by 5:00 PM with continuation of oncoming staff and follow-up. Monitoring/Verification of Plan of removal The POR were reviewed as followed. The facility created a binder and numbered each tab in the binder with the completed documented necessary to fulfill the plan. Sunday [DATE] 0657 POR -care plan posttest was initiated on [DATE]. -MDS nurse and corporate MDS nurse initiated for all fall interventions, this information was also added to the kardex. In progress. Inservice was also given with all staff on how to use the Kardex and review the care plan. -1:1 Inservice was given MDS nurse. This had been completed. -20 staff members had completed an Inservice on all above listed policies and training in the POR. -there are a total of 79 employees total listed on the employee roster. 43 are direct care staff. Monday [DATE] Interviews: In an interview with LVN A at 11:16 pm, she said that all forms of suspected abuse were to be reported to the abuse coordinator, the Admin. If a resident [NAME] they were supposed to report it to the DON and she would call the family and the doctor. For fall assessments, they nurses would complete skin checks, vitals, range of motion, and a pain assessment. After that had been completed, aides could pick the resident off of the floor. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA F at 1:22 pm, she stated they covered what staff would do when someone fell . She said they would not move the resident and would wait until the nurse got there and did the vitals. It was not ok to move the resident unless the nurse had checked the vitals and they were ok. If they needed to go to the hospital, then the paramedics would move them. Tuesday [DATE] On Tuesday [DATE] from 4:30 pm - 6:00 pm, calls were made to staff who were on the alternate rotating 12 hour schedule. A total of 14 calls were made from staff who worked the 6am-6pm and the 6pm-6am shift. Seven calls were successful. NA E call at 4:34 p.mm., 6am-6pm shift She stated for abuse and neglect, they covered the bruising and if they saw any bruising, the way someone talked to a resident, she should report immediately after witnessing it to the abuse coordinator. Different types of abuse were verbal, physical, and neglect. When witnessing a fall, staff immediately reported to charge nurse and would not mess with them. The charge nurse would check the vital signs immediately after the fall. Staff only moved the resident after the charge nurse gave them the permission to move them. CNA C called at 4:42 pm.m., 6am-6pm shift, PRN Said she had not been to work since the following week and had not covered the abuse and neglect trainings yet but she would be returning to work the following day. When a resident fell , she would leave them there and go get the nurse. The nurse would examine them and they would not be able to lift them up or touch them until after they has been examined after a fall. CMA C called 4:59 pm.m., 6a-6p For abuse and neglect they covered about reporting if they saw anything, like from another staff or another resident, they have to report it immediately. The abuse coordinator was the Admin and the different types of abuse were hitting, kicking, biting and scratching. For falls, they were supposed to get the nurse immediately and don't move them. They left them there and asked if they were ok. The nurse needed to check and they have to makes sure the resident was ok and have someone watching. CNA G called at 6:44 pm.m., 6am- 6pm shift They covered what was abuse and neglect and the importance in making sure everybody was in communication and documenting. The priority was to make sure residents were safe and secure. Some examples were mental, physical, and financial. The abuse coordinator was the Admin and all abuse should be reported immediately. When a resident fell , don't touch them and call the nurse. Let them get viewed and don't touch them until the nurse said it was ok. Aides do an incident report and follow up. She explained the Kardex was used to let you know what is happening with the resident, where their room was, what their plan of care was, and what we have to chart for. To find the Kardex she would sign in, got to the POC, go to different labels, and find the chart that said Kardex and open it up. The Kardex showed things about the resident like meals, blood pressure, and gave some familiarity with what was going on with the resident (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA H called at 5:18 pm.m., 6am-6pm shift, PRN The abuse and neglect training covered the verbal, physical, financial, mental, and emotional. The abuse coordinator was the administrator and an example would be if she saw someone saying a resident couldn't spend their money or they couldn't have their own belongings. If a resident fell , staff must let a charge nurse know immediately and don't pick them up. Staff can pick the resident up after all the vitals, the nurse checked them, and if there were no broken bones. She explained the Kardex showed their care plan and when you got into the portal and got to the resident's name, it should be on the right hand side. CNA I called at 5:25 pm.m., 6pm-6am shift Abuse and neglect training covered that any issues with residents should be reported immediately. To report, go straight to the nurse and if they couldn't do anything go over them. We should report as soon as possible on any concerns. Different types were sexually, neglect, physically and verbal. The abuse coordinator was the Admin. For falls, aides should ask if the residents were ok and the nurse would range of motion and check them. Aides were allowed to pick them up off of the floor after the nurses assessed the resident and it was ok to pick up them up. She explained the Kardex was used for the plan of care and charting. To locate the Kardex, you go to the resident's name and it should be on the right hand side. CNA J called at 5:38 pm.m., 6am-6pm shift Stated you report all abuse to the abuse coordinator and the different types of abuse are neglect, physical, sexually, mental, and emotional. When they fall, he would call the nurse right away. The nurse would check the resident and ask to find out what happened. He would pick them off the floor when everything was completed. He could not remember his training on the Kardex and this was relayed to the Admin and New DON. In an interview on [DATE] at 5:55 p.m. with LVN B, he stated that he worked from 6pm - 6am. The abuse and neglect training covered that all reportables should be taken to the abuse coordinator who is the Admin. After a resident falls, he will do his assessment from head to toe and will not let an aide touch the resident until after he has cleared them. Whenever there is a change in condition for a resident (sickness, coughing, change of temperature, or after a fall) he will create a change of condition form. Afterwards, he would alert the DON, contact the doctor, and reach out to the family. The care plan should be updated quarterly and as needed. The care plan meetings usually consisted of the doctors, DON, ADON, and social worker. In an interview on [DATE] at 6:00 pm.m., at LVN C, she stated that worked the 6pm-6am shift and she was on her second day. In the abuse and neglect training, they covered that staff should take all reports to her and she would pass the report along to the abuse coordinator. If someone fell , she would perform a range of motion assessment, neuro check, make sure nothing was broken, check movement, pain levels, and bruising or discoloration of the skin Whenever there is a change in condition for a resident (sickness, coughing, change of temperature, or after a fall) she would create a change of condition form. Afterwards, he would alert the DON, contact the doctor, and reach out to the family. The care plan should be updated quarterly and as needed. The care plan meetings usually consisted of the doctors, DON, ADON, and social worker. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 6:14 pm.m., LVN D stated that she worked the 6pm-6am shift. In the abuse and neglect in-service, all suspected abuse she be reported to the abuse coordinator immediately. The type of assessments done if a resident falls, were breathing, pain, ROM, and vitals. CNAs were only able to pick a resident off the floor after the assessment and there were not injured. We have to say it is safe to pick them up. The care plan should be undated every 90 days and with any change in condition. Nurses should do a change of condition form when there is any type of change like fever, diarrhea, or a fall. They would notify the doctor, family, and DON. For creating the comprehensive care plan, some of the nurse would be a part of the care plan meeting such as the DON, ADON, family, and the resident could join as well. This would also include everyone who is a part of administration. Record review of the facility's policy titled Care Plans, Comprehensive Person- Centered revised [DATE], displayed: 1. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment d. Describe any specialized services to be provided as a result of PASARR recommendations e. Include the resident's stated goals upon admission and desired outcomes f. Include the resident's stated preference and potential for future discharge, including his or her desire to return to the community and any referrals made to local agencies or other entities to support such a desire g. Incorporate identified problem areas h. Incorporate risk factors associated with identified problems i. Build on the resident's strengths j Reflect the resident's expressed wishes regarding care and treatment goals (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	k. Reflect treatment goals, timetables and objectives in measurable outcomes l. Identify the professional services that are responsible for each element of care m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and o. Reflect currently recognized standards of practice for problem areas and conditions. 2. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 3 Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. a. No single discipline can manage an approach in isolation. b. The resident's physician (or primary healthcare provider) is integral to this process. 4. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. b. Care planning individual symptoms in isolation may have little, if any, benefit for the resident. 512. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 613. Assessments of residents are ongoing and care plans are revised as information about the residents and the (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents' conditions change. 714. The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition b. When the desired outcome is not met c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment. 815. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies. The administrator was notified that the IJ was removed on [DATE] at 07:35pm, however the facility remained out of compliance at a scope of isolated and a level of minimal harm due to the facility's need to monitor the implementation of the plan of removal.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on interviews and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of seven residents reviewed for quality of care. 1. The facility delayed Resident #1 a transfer to the hospital for higher level of care and delayed treatment resulting in prolonged discomfort and pain. An IJ was identified on 06/07/24. The IJ template was provided to the facility on [DATE] at 6:13 pm. While the IJ was removed on 06/11/24, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal. This failure could place residents at risk of decline or decrease in their quality of life and quality of care. Findings included: Record review of Resident #1's face sheet revealed a sixty-five-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses included contractures to the left knee, right knee, left shoulder, and muscle; hemiplegia (partial paralysis); cerebral infraction (stroke); abnormal posture; and major depressive disorder. Record review of Resident #1's care plan revealed that she had left sided hemiplegia/hemiparesis. Interventions initiated 11/15/21 listed to complete range of motion (active or passive) with am/pm care daily. Resident was at risk for pain due to joints, history of poliomyelitis, and muscle spasms. Intervention (initiated 11/15/21) stated to monitor for vocalizations (yelling out) and face (crying and worried). Care plan also indicated that on 05/16/24, resident was required to use a hoyer lift for all transfers. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 04/22/24 revealed a score of 13/15, cognitively intact. Record review of Resident #1's MDS Section G- Functional Abilities and Goals dated 06/01/24 revealed that Resident #1's functional limitations range of motion were impaired on both sides. Review of the subsection titled Mobility, Resident #1 was completely dependent with sitting to lying and lying to sitting. Walking, sitting to stand, and self-wheeling were not attempted due to medical condition and safety concerns. Record review of Resident #1's hospital records (post ER transfer) reflected that she was admitted on [DATE] at 4:51 pm. Her admitting diagnoses was a right femur fracture and acute pain due to trauma. Treatment included intramedullary nailing (is surgery to repair a broken bone and keep it stable)of the right femur. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER: Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 603 E Plantation Rd Clute, TX 77531	

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's progress note, written on 05/24/24 by LVN Nurse A at 9:31 a.m., displayed that CNA was transferring patient onto wheelchair from Hoyer Lift, as patient was lowered into chair, patient slid off of the wheelchair to the ground. Pain, neuro, and skin assessments yielded no abnormal findings, suggest no trauma, VS all WNL. Patient startled but denies pain. Responsible party, PCP, and DON notified of incident. Will continue to monitor. Record review of the facility's In-service trainings from January 2024-June 2024, revealed that a hoyer lift training was conducted from 05/29/24- 06/05/24. No other trainings were found. In an interview on 06/05/24 at 1:56 pm, CNA A stated that she was familiar with Resident #1, and she was switched to a hoyer lift transfer during the month of May. She stated that around 9 am on 05/24/24, NA B and herself were transferring Resident #1 from the hoyer lift to the wheelchair in the hallway. She explained that while she controlled the hoyer controls, CNA was supposed to hold the wheelchair. While the resident was being lowered down, NA B let go of the wheelchair to straighten Resident #1. Due to NA B letting go of the wheelchair so quickly, Resident #1 was described to slide out the wheelchair and land on her leg in pain. When she fell , she cried out in pain in instantly. LVN Nurse A came to assess the resident and she was crying because she was in a lot of pain. CNA stated that she asked LVN Nurse A to send her out, but he did not send Resident #1 out until after the family arrived that evening. She explained with tears in her eyes that this situation had really hurt her because her family and Resident #1's family were close, and she was angry that LVN Nurse A did not send her out right away. An interview was attempted on 06/05/24 at 2:22 pm with Resident #1. She stated she was very tired, and the interview would be completed at a later time. An interview was attempted on 06/05/24 at 3:42 pm, with NA B a voicemail and text message were sent out requesting a call back. In an interview on 05/24/24 at 4:27 pm, LVN Nurse A stated that he had started working at the facility on 05/02/24. He stated that on 05/24/24 when Resident #1 fell , he was working with another resident when he heard a loud scream in pain. He ran into the hall and saw Resident #1 on the floor next to the hoyer lift. He stated that he provided neuro checks for the resident, took vitals, and did a skin assessment, however he did not perform ROM. LVN Nurse A stated he did not perform ROM on Resident #1 because she was fully contracted and whenever he would move her limbs, she would grimace due to pain. His focuses were the points of contact made with the ground. He explained that Resident #1 was well aware of what happened, he did not hear her say anything about pain, and felt that she was more startled than anything. He stated after the fall, he contacted the doctor, NP, and the family. LVN Nurse A stated that he performed checks every 2 hours around 12:00 pm, he noticed some swelling on her right hip, but thought it was due to the resident being contracted. When the family arrived at 4:30 pm, that evening, he stated that they confronted him and she was in severe pain. She was given pain medication at that time, and he attempted to reach out to the doctor and the NP, both who were unavailable. He informed the family that an X-ray could be done, but the technicians would not arrive to the facility until Tuesday due to the holiday. He felt that nothing was wrong with Resident #1 based off his assessment but the family did not want to wait and requested to send her out. LVN Nurse A denied Resident #1 crying but stated that when he asked her to describe her pain level on a scale of 1 (being the lowest) and 10 (being the highest), she stated a 9. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake Nursing Center	603 E Plantation Rd Clute, TX 77531

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In an interview on 06/05/24 at 4:44 pm, with Resident #1 and her family member, Resident #1 stated that when she fell on [DATE], she was crying the entire time and she yelled out very loudly when she dropped because the fall hurt. The family member stated that she arrived to the facility at 3:30 pm and when she tried to adjust Resident #1 in bed for an afternoon snack, she yelled out very loudly and said Stop, Stop! It hurts!. She told LVN Nurse A that she was in pain but he told her the doctor would not be available until Tuesday, which they were not comfortable with. Family member explained that whenever she came to the facility, she was always able to adjust Resident #1's legs without any problem and Resident #1 stated that it did not hurt when she did this. Family member told LVN Nurse A that her hip and arm were swollen. Once LVN Nurse A decided to send her out, she was taken by the emergency services, then was transferred to a major hospital in a bigger city for immediate surgery.

In a follow up interview on 06/05/24 at 5:06 pm, CNA A said that when LVN Nurse A was assessing Resident #1, she was crying and told him that it hurt. She stated that she heard Resident #1 tell LVN Nurse A that she was hurting from the fall and she explained that from the way she was crying, she knew she was in pain.

In an interview on 06/07/24 at 11:29 am, NA B stated that she had been working at the facility for 3 weeks. She stated that initially, she was walking down the hall when CNA A asked if she could assist her with a hoyer transfer with Resident #1. She explained that during the transfer, Resident #1 was not sitting in the sling correctly. As CNA A lowered the resident down into the chair, she slid out of the chair and onto the floor because she felt like the seat pillow was not positioned right. She said that she didn't think she fell very hard but stated that she was not sure because Resident #1 is an elder and was contracted. NA B felt that Resident #1 screamed when she fell because she was more scared than hurt. She explained that when LVN Nurse A did the post fall assessment, he did not extend her legs out, but he did take her vitals. NA B also stated that prior to this incident, she had not received any hoyer lift training at the facility and that was her first time performing a Hoyer transfer with a human being and not a plastic dummy.

In an interview on 06/07/24 at 12:46 pm, with the DON, she stated that when Resident #1 fell , she was told it was because she was not placed in the wheelchair correctly. She stated that if she was assessing the resident, she would not have done a ROM assessment because she was contracted, but if she did, she would be very careful. She stated that she never liked the hoyer lift and there should always be two people operating it at a time. She expressed that she was not aware that LVN Nurse A did not perform ROM when he assessed her and stated that it if the resident hit their head or had an obvious fracture, they would need to be sent out.

The Administrator was notified of the IJ on 06/07/24 at 6:13 p.m and given the IJ template due to the above failures and a POR was requested.

The POR was accepted on Sunday 06/09/24 at 9:17 am, and reflected the following:

Re: Plan of Removal of Immediate Jeopardy

F0684

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 603 E Plantation Rd Clute, TX 77531	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following is a plan of removal, which was immediately implemented at XXX, to remedy the Immediate Jeopardy which was imposed 6/7/24 at approximately 6:22 PM. The notification of Immediate Jeopardy states as follows: F684 All items listed will be completed by 5:00 pm on 6/8/24 with continued follow-up for scheduled staff. 1. Administrator/DON initiated an in-service for all staff on 6/7/24 on incident/accident policy and abuse neglect exploitation. A post-test will be performed with staff over information in-serviced on by administration, and a score of 100% must be achieved. If less than 100%, staff will be reeducated and retest until 100% is achieved. 2. In-service initiated on 6/7/24 by the administrator and DON regarding changes in condition policy and procedure and residents needing higher level of care for injuries/assessment findings for all licensed clinical staff. 3. Administrator/DON initiated an 1:1 Inservice with LVN Nurse A regarding assessment of a resident post fall and recognizing assessment changes of condition that warrant higher level of care. 4. Administrator and DON were in-serviced on 6/7/24 by Regional Director of Clinical Services on all the policies mentioned above, and to notify regional/corporate staff of ALL falls/incidents, and are to notify regional/corporate staff of any discrepancies. Regional/corporate staff will follow-up on each fall/incident in question and direct with appropriate interventions. If staff are unable to attend any of the in-services, they will be required to complete the in-service before starting their assigned shift. Any agency will be in-serviced prior to the beginning of their shift. Any new hires will be in-serviced on hire, prior to working a shift. The Medical Director was made aware of the Immediate Jeopardy 6/7/24 at 6:49 pm and has been involved in developing the Plan of Removal. These conversations are considered part of the QA process. A QAPI meeting was held on 6/7/24 with attendance of Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Regional Director of Clinical Services, and Regional Director of Operations. This plan was initially implemented 6/7/24 and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is 6/8/24 by 5:00 pm with continuation of oncoming staff and follow-up. Monitoring/Verification of Plan of removal The POR were reviewed as followed. The facility created a binder and numbered each tab in the binder with the completed documented necessary to fulfill the plan. Plan 0684 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 had her care plan updated. Also had discharge orders in place. -an all staff Inservice was initiated on 06/07/24 and staff were required to take a fall assessment test. -an Inservice for the DON and Admin regarding changes to condition policy was initiated on 06/07/24. This task was completed. -a 1:1 in-service was attempted for LVN Nurse A, but LVN Nurse A put in his resignation letter on 06/08/24. He wished to be released on the spot. -Admin and DON were in serviced on 06/07/24 by RDCS on all policies mentioned in POR. This was completed. -residents were assessed regarding any changes in condition. For verification, staff were asked to provide a resident roster in the form of a spreadsheet to show which residents had a change in condition update, care plan update, or any new orders per the POR. Monday June 10, 2024 The interviews were as followed regarding in-service topics: In an interview with RN A at 12:36 pm, he stated they talked about who to notify if abuse and neglect were suspected and who to look for if you suspect something happened. Things to look for may be bruises and injuries. The abuse coordinator is the Admin and the reporting time is within 2 hours. In an Interview with CNA E at 12:41 pm, she stated that in the abuse and neglect in-service, they talked about who was the abuse coordinator and who do they report to. They report to nurse first, then ADON, DON, and Admin. The abuse coordinator was the Admin. Reportables were anything physical, neglect, money situation or abuse of funds, and verbal. Examples were bruising on the body or anything foreign. In an interview with NA C at 12:51 pm, she stated that for abuse and neglect, they discussed if someone saw someone doing something harmful, immediately report it. The chain of command was nurse, ADON, and DON, then Admin. The abuse coordinator was the Admin. Types were physical, emotional, verbal, and sexual. She explained when a resident falls, they immediately report it to nurse. From there the Admin and DON, ADON. The nurse checked it out and saw if they could lift them or any issues. If so, they would send them out. If a resident falls, she would wait for a nurse to come and check them. In an interview with CMA A at 12:58 pm, he explained that for abuse and neglect, they covered if they noticed abuse and neglect. Types were verbal, sexual, physical, neglect. If suspected, they would report it to their Admin, who was the abuse coordinator. For falls, they would go to charge nurse first so they can come and assess the resident before they touch or do anything with them. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CMA B at 1:05 pm, they covered that if they saw any abuse, they were to report it to the charge nurse. The abuse coordinator was the Admin. She stated that if she saw a resident on the ground, she would stay with the resident and she would holler for an aid or a changer nurse to come help. She would not pick the resident off the floor. She would wait for the charge nurse and pick them up when the charge nurse said it was ok and the assessment had been completed. In an interview with LVN A at 11:16 pm, she said that all forms of suspected abuse were to be reported to the abuse coordinator, the Admin. If a resident falls, they were supposed to report it to the DON and she would call the family and the doctor. For fall assessments, they nurses would complete skin checks, vitals, range of motion, and a pain assessment. After that has been completed, aides could pick the resident off of the floor. In an interview with CNA F at 1:22 pm, she stated they covered what staff would do when someone fell . She said they would not move the resident and would wait until the nurse got there and did the vitals. It was not ok to move the resident unless the nurse had checked the vitals and they were ok. If they needed to go to the hospital, then the paramedics would move them. For abuse and neglect, they covered that when they see abuse and neglect, they must report it to the abuse coordinator, the Admin. She gave the example that some different types of abuse were emotional, sexual, physical, mental, or stealing from residents. An example she gave was when she saw an old coworker years ago at a different facility get hit by a resident and she responded by hitting them back. She reported it immediately. A hoyer lift observation was witnessed on 06/10/24 at 1:33 pm with Resident #1, NA C, NA D (who observed), CNA E, and RN A. CNA E strapped Resident #1's legs in the harness while she was sitting in the wheelchair. NA C used the controls to lift her slowly up in the hoyer while she was in a sitting position. They moved the wheelchair back and RN A grabbed the back on the sling and adjusted Resident #1 above the bed. She was laid gently in the bed by NA D, who held her legs in a slightly bent position due to her contractures. Resident #1 said she was ok during the transfer and she was not in pain. No concerns with transfer. In an interview on 06/11/24 at 5:55 pm with LVN B, he stated that he worked from 6pm - 6am. The abuse and neglect training covered that all reportables should be taken to the abuse coordinator who was the Admin. After a resident fell , he would do his assessment from head to toe and would not let an aide touch the resident until after he had cleared them. He also stated that on his shift, he would be the nurse to watch all hoyer lift transfers and residents in the lift should be sitting in an upright position. Whenever there was a change in condition for a resident (sickness, coughing, change of temperature, or after a fall) he would create a change of condition form. Afterwards, he would alert the DON, contact the doctor, and reach out to the family. The care plan should be updated quarterly and as needed. The care plan meetings usually consisted of the doctors, DON, ADON, and social worker. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/11/24 at 6:00 pm at LVN C, she stated that worked the 6pm-6am shift and she was on her second day. In the abuse and neglect training, they covered that staff should take all reports to her and she would pass the report along to the abuse coordinator. If someone fell , she would perform a range of motion assessment, neuro check, make sure nothing was broken, check movement, pain levels, and bruising or discoloration of the skin. When a hoyer lift transfer was to be performed, she would be monitoring for a safe transfer and she was comfortable with the training. Whenever there was a change in condition for a resident (sickness, coughing, change of temperature, or after a fall) she would create a change of condition form. Afterwards, he would alert the DON, contact the doctor, and reach out to the family. The care plan should be updated quarterly and as needed. The care plan meetings usually consisted of the doctors, DON, ADON, and social worker. In an interview on 06/11/24 at 6:14 pm, LVN D stated that she worked the 6pm-6am shift. In the abuse and neglect in-service, all suspected abuse should be reported to the abuse coordinator immediately. The type of assessments done if a resident fell , were breathing, pain, ROM, and vitals. CNAs were only able to pick a resident off the floor after the assessment and there were not injured. Nurses have to say it was safe to pick them up. Hoyer transfers should always be done with 2 aides and nurse to monitor. The care plan should be updated every 90 days and with any change in condition. Nurses should do a change of condition form when there was any type of change like fever, diarrhea, or a fall. They would notify the doctor, family, and DON. For creating the comprehensive care plan, some of the nurses would be a part of the care plan meeting such as the DON, ADON, family, and the resident could join as well. This would also include everyone who was a part of administration. Record review of sign in sheets for Abuse and neglect inservice started 06/07/24reflected that all staff had been in serviced regarding the topics listed in the POR on both rotating shifts and for the day and night shifts as well. Review of the quizzes covering the topic of abuse and neglect reflected that al quizzes had been completed with a score of 100%. Record review of the in-service dated 06/08/24 covering the topic of Admin, DON, ADON will notify corporate of all falls/incidents and any discrepancies displayed that it had been completed. Record review of a termination letter from LVN Nurse A dated 06/08/24 revealed that LVN Nurse A wished to resign immediately due to an out of state family emergency. Record review of the facilities Abuse and neglect Policy revised April 2021 stated: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included but was not limited to freedom from corporal punishment and voluntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The facility should develop and implement policies and protocols to prevent and identify a. abuse or mistreatment of residents b. neglect of residence c. theft, exploitation or misappropriation of resident property. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility should provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Record review of the facilities policy titled Accidents and Incident- Investigating and Reporting revised July 2017 stated: The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Record review of the facilities policy titled Change in a Resident's Condition or status revised February 2021, displayed: 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting); b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: a. the resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. there is a significant change in the resident's physical, mental, or psychosocial status; c. there is a need to change the resident's room assignment; d. a decision has been made to discharge the resident from the facility; and/or e. it is necessary to transfer the resident to a hospital/treatment center. The administrator was notified that the IJ was removed on 06/11/24 at 07:35 pm, however the facility remained out of compliance at a scope of isolated and a level of minimal harm due to the facility's need to monitor the implementation of the plan of removal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
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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** 46561 Based on interviews and record reviews the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents for two (Resident #1 and Resident #2) of five residents reviewed for accidents hazards and supervision, in that: 1. The facility failed to make sure staff were properly trained before operating the hoyer lift. Resident #1 sustained a hip fracture during a Hoyer lift transfer by CNA A and NA B, which required surgical intervention. 2. Resident #2 was placed into his wheelchair and left unattended after a decline in his health caused him unsteady trunk balance and support. He fell out of the wheelchair, hit his face, and was transferred to the emergency room . An IJ was identified on 06/07/24. The IJ template was provided to the facility on [DATE] at 6:13 pm. While the IJ was removed on 06/11/24, the facility remained out of compliance at a scope of isolated and a severity level of not actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor the implementation of the plan of removal. The failure could place residents at risk of experiencing accidents, injuries, and/or death. The findings included: Resident #1 Record review of Resident #1's face sheet revealed a sixty-five-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were contractures to the left knee, right knee, left shoulder, and muscle; hemiplegia (partial paralysis); cerebral infraction (stroke); abnormal posture; and major depressive disorder. Record review of Resident #1's care plan completed 05/28/24 revealed that she had left sided hemiplegia/hemiparesis. Interventions initiated 11/15/21 listed to complete range of motion (active or passive) with am/pm care daily. Resident was at risk for pain due to joints, history of poliomyelitis, and muscle spasms. Intervention (initiated 11/15/21) stated to monitor for vocalizations (yelling out) and face (crying and worried). Care plan also indicated that on 05/16/24, resident was required to use a hoyer lift for all transfers. Record review of Resident #1's MDS dated [DATE](clinical assessment to determine resident's strength and needs) Quarterly Assessment Section C - Cognitive Patterns dated 04/22/24 revealed a score of 13/15, cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 E Plantation Rd Clute, TX 77531	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MDS dated [DATE]Quarterly Assessment Section G- Functional Abilities and Goals dated 06/01/24 revealed that Resident #1's functional limitations range of motion were impaired on both sides. Review of the subsection titled Mobility, Resident #1 was completely dependent with sitting to lying and lying to sitting. Walking, sitting to stand, and self-wheeling were not attempted due to medical condition and safety concerns. Record review of Resident #1's hospital records (post ER transfer) reflected that she was admitted on [DATE] at 4:51 pm. Her admitting diagnoses were a right femur fracture and acute pain due to trauma. Record review of the facility's In-service trainings from January 2024-June 2024, revealed that a hoyer lift training was conducted from 05/29/24- 06/05/24. No other trainings were found. Record review of Resident #1's progress note, written on 05/24/24 by LVN Nurse A at 9:31 a.m., displayed that CNA was transferring patient onto wheelchair from Hoyer Lift, as patient was lowered into chair, patient slid off of wheelchair to the ground. Pain, neuro, and skin assessments yielded no abnormal findings, suggest no trauma, VS all WNL. Patient startled but denies pain. Responsible party, PCP, and DON notified of incident. Will continue to monitor. In an interview on 06/05/24 at 1:56 p.m., CNA A stated that she was familiar with Resident #1, and she was switched to a hoyer lift transfer during the month of May. She stated that around 9 a.m. on 05/24/24, NA B and herself were transferring Resident #1 from the hoyer lift to the wheelchair in the hallway. She explained that while she controlled the hoyer controls, CNA was supposed to hold the wheelchair. While the resident was being lowered down, NA B let go of the wheelchair to straighten Resident #1. Due to NA B letting go of the wheelchair so quickly, Resident #1 was described to slide out the wheelchair and land on her leg in pain. When she fell , she cried out in pain in instantly. LVN Nurse A came to assess the resident and she was crying because she was in a lot of pain. CNA stated that she asked LVN Nurse A to send her out, but he did not send Resident #1 out until after the family arrived that evening. She explained with tears in her eyes that this situation had really hurt her because her family and Resident #1's family were close, and she was angry that LVN Nurse A did not send her out right away. An interview was attempted on 06/05/24 at 2:22 p.m., with Resident #1. She stated she was very tired, and the interview would be completed at a later time. An interview was attempted on 06/05/24 at 3:42 p.m., with NA B a voicemail and text message were sent out requesting a call back. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 05/24/24 at 4:27 p.m., LVN Nurse A stated that he had started working at the facility on 05/02/24. He stated that on 05/24/24 when Resident #1 fell , he was working with another resident when he heard a loud scream in pain. He ran into the hall and saw Resident #1 on the floor next to the hoyer lift. He stated that he provided neuro checks for the resident, took vitals, and did a skin assessment, however he did not perform ROM. LVN Nurse A stated he did not perform ROM on Resident #1 because she was fully contracted and whenever he would move her limbs, she would grimace due to pain. His focuses were the points of contact made with the ground. He explained that Resident #1 was well aware of what happened, he did not hear her say anything about pain, and felt that she was more startled than anything. LVN Nurse A stated that he performed checks every 2 hours around 12 pm, he noticed some swelling on her right hip, but thought it was due to the resident being contracted. When the family arrived at 4:30 pm that evening, he stated that they confronted him and he was in severe pain. She was given pain medication at that time, and he attempted to reach out to the doctor and the NP, both who were unavailable. He informed the family that an X-ray could be done, but the technicians would not arrive to the facility until Tuesday due to the holiday. He felt that nothing was wrong with Resident #1 based off his assessment but they family did not want to wait and requested to send her out. LVN Nurse A denied Resident #1 crying but stated that when he asked her to describe her pain level on a scale of 1 (being the lowest) and 10 (being the highest), she stated a 9. In an interview on 06/05/24 at 4:44 p.m., with Resident #1 and her family member, Resident #1 stated that when she fell on [DATE], she was crying the entire time and she yelled out very loudly when she dropped because the fall hurt. The family member stated that she arrived to the facility at 3:30 pm and when she tried to adjust Resident #1 in bed for an afternoon snack, she yelled out very loudly and said Stop, Stop! It hurts!. She told LVN Nurse A that she was in pain but he told her the doctor would not be available until Tuesday, which they were not comfortable with. Family member explained that whenever she came to the facility, she was always able to adjust Resident #1's legs without any problem and Resident #1 stated that it did not hurt when she did this. Family member told LVN Nurse A that her hip and arm were swollen. Once LVN Nurse A decided to send her out, she was taken by the emergency services, then was transferred to a major hospital in a bigger city for immediate surgery. In an interview on 06/07/24 at 11:29 a.m., NA B stated that she had been working at the facility for 3 weeks. She stated that initially, she was walking down the hall when CNA A asked if she could assist her with a hoyer transfer with Resident #1. She explained that during the transfer, Resident #1 was not sitting in the sling correctly. As CNA A lowered the resident down into the chair, she slid out of the chair and onto the floor because she felt like the seat pillow was not positioned right. She said that she didn't think she fell very hard but stated that she was not sure because Resident #1 is an elder and was contracted. NA B felt that Resident #1 screamed when she fell because she more scared than hurt. She explained that when LVN Nurse A did the post fall assessment, he did not extend her legs out, but he did take her vitals. NA B also stated that prior to this incident, she had not received any hoyer lift training at the facility and that was her first time preforming a hoyer transfer with a human being and not a plastic dummy. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/07/24 at 12:46 p.m., with the DON, she stated that when Resident #1 fell , she was told it was because she was not placed in the wheelchair correctly. She stated that if she was assessing the resident, she would not have done ROM because she was contracted, but if she did, she would be very careful. She stated that she never liked the hoyer lift and there should always be two people operating it at a time. DON stated that a hoyer lift transfer in service had been started on 05/29/24, but she was informed that this was after the fall with Resident #1. She stated that she would need to check the in-service binder for more documentation. No additional in-services were provided. The DON expressed that she was not aware that LVN Nurse A did not perform ROM when he assessed her and stated that it if the resident hit their head or had an obvious fracture, they would need to be sent out. Resident #2 Record review of Resident #2's face sheet revealed an eighty-year-old man admitted on [DATE]. His admitting diagnoses were atherosclerosis of arteries (build up in arteries) in right and left leg with ulceration of foot, contractures of muscle in right and left lower leg, pain in right and left knee, and stiffness of unspecified joint. Resident #2 was also on hospice. Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) Section C - Cognitive Patterns dated 05/24/24 revealed a score of 0/15, severely impaired. Record review of Resident #2's MDS Section G- Functional Abilities and Goals dated 05/24/24 revealed that Resident #2 was totally dependent for bed mobility and transfers. He also was categorized as a two-person physical assist. Record review of Resident #2's care plan (revised 05/15/24) revealed that he was at risk for falls related to gait/balance problems, paralysis/contracture, vision/hearing problems and cognitive loss. Interventions prior to fall listed to encourage resident to lay in center of bed (dated 01/16/23), anticipate and meet needs (revised 04/05/21), and to monitor in wheelchair for safety (post fall, 05/15/24). Care plan also stated that he was placed on hospice on 04/16/24 and interventions included to adjust provision of ADLS to compensate for changing abilities. Record review of Resident #2's progress note dated on 03/28/24 at 05:30 pm revealed that LVN E discussed with a family member that Resident #2 had been refusing to eat, take his medication, and there had been a decline is his ADLs. The option of hospice was suggested to the family. Record review of Resident #2's progress note dated on 04/03/24 at 11:26 am, LVN E spoke with another member of the family and expressed her concern for Resident #2's decline due to his low food and fluid intake. Family member stated that they had decided to move forward with hospice and they were in the process of choosing a company. Record review of Resident #2's progress note dated on 04/04/24 at 10:56 am, LVN E documented that a hospice company was selected. Record review of Resident #2's progress note dated on 04/07/24 at 11:55 am, RN B documented the resident had his first hospice visit and received comfort supplies. (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 Resident #2's progress note dated on 05/15/24 at 5:06 pm, WCN documented that the resident had an unwitnessed fall and was found on the floor with a laceration to his right eyebrow. Record review of Resident #2's progress note dated on5/15/24 at 9:18 pm, WCN documented that the resident returned to the facility in a wheelchair by transport vehicle. In an interview on 06/05/24 at 2:48 pm, CNA E stated that Resident #2 was a total care resident and was currently on hospice. She said that he used to get up in his wheelchair and sit in the dining room but ever since he was placed on hospice, they no longer did a lot with him. She stated that she did not work the day of his fall on 05/15/24 but she was confused on why the staff got him out of bed. She explained that Resident #2 no longer had balance and he could not sit in a wheelchair. In an observation on 06/05/24 at 4:03 pm, Resident #2 was in bed asleep. His bed was in a low position and side rails were in place as well as a fall mat. A wheelchair was folded against the wall and displayed that it was from the hospice company. In an interview on 06/05/24 at 4:05 pm with WCN, she stated that she had worked at the facility for 1 year but she had never seen Resident #2 out of bed. She explained that he was constantly in pain, with 2 pressure ulcers and 4 arterial wounds. When he returned to the facility after his fall, he had steristrips covering the laceration on his forehead that healed in a week or so. She stated that he did have a wheelchair but believed the wheelchair had been provided from hospice. In an interview on 06/07/24 at 12:07 pm, with CNA C, she stated that the Restorative aide was in Resident #2's room and she asked her for help to get him out of bed and into his wheelchair on 5/15/24. She explained that Resident #2 had stopped getting up a month prior to this incident and if they did, it would be dependent on how he felt. She stated that after she helped the Restorative Aid, she stated that the aide did not recline his chair and she guessed that he fell forward and had a gash above his right eye. She did not see the fall but stated that he was sent out using emergency services to make sure he was alright. In an interview on 06/07/24 at 12:24 pm, with the Restorative Aide, she stated that on 05/15/24, she walked past Resident #2's room and asked the resident if he wanted to get out of bed, in which he replied, yea baby. With the help of CNA C, she transferred him into the wheelchair and set his bedside table up in front of him. She asked him did he want coffee, and she left the room along with CNA C to grab some coffee. When the Restorative Aide returned to the room with the coffee, she set it on his table, asked if he was ok, and left out the room. Several minutes later, she heard staff screaming and when she came back to the room, she saw the bedside table knocked over on the floor, Resident #2 had fallen out of the wheelchair onto the floor, and his head was laid against the leg of the table. After, an in-service was done that covered from the RD that if Resident #2 was in a sitting position, his wheelchair needed to be reclined back. She explained that she didn't originally recline his wheelchair back because he was drinking coffee and she was trying to align his body. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/07/24 at 12:46 pm, with the DON, she stated that Resident #2 had been getting worst in the past few months and he was placed on hospice 2 months prior. She stated that he had passed away in his sleep on 06/06/24 around 2:30 am. She stated that he fell out of his wheelchair on 05/15/24, but she was not there. She stated that she thought he was too weak and suggested that maybe he had tried to grab something from his bedside table. Resident #2 did hit his head, but his results came back negative. She denied that he should have been sitting a certain way. She stated that the staff had stopped getting him out of bed as frequently because she was worried about him sitting in his wheelchair for extended periods of time. An attempted call was made on 06/07/24 at 1:28 pm to the NP. A voicemail was left requesting a call back. An attempted call was made on 06/08/24 at 1:26 pm, to the hospice nurse. A voicemail was left requesting a call back. In an interview on 06/08/24 at 1:48 p.m., with the RD, she sated that Resident #2 had a chair from hospice and it did recline. She could tell that he hit his head on the base of the table and said that from then on, she instructed all aides to recline his chair because he could not recover his strength to bring his body back after he reached for something. She stated that he had not been out of his wheelchair in a least a week or so, but he used to be able to sit in a normal wheelchair. She stated that he did not have the trunk stability to bring himself back upright in a wheelchair so she made the recommendation after the fall to have him reclined when he sat. The Administrator was notified of the IJ on 06/07/24 at 6:13 p.m. and given the IJ template due to the above failures and a POR was requested. On 06/09/24 at 9:17 am, the POR was accepted. It was documented as follows: Re: Plan of Removal of Immediate Jeopardy The following is a plan of removal, which was immediately implemented at XXX to remedy the Immediate Jeopardy which was imposed 6/7/24 at approximately 6:22 PM. The notification of Immediate Jeopardy states as follows: F689 All items listed will be completed by 5:00 PM on 6/8/24 with continued follow-up for scheduled staff. 1. On 6/7/24 a hoyer lift in-service was initiated to include return demonstration with all direct care staff. Direct care staff will not be allowed to hoyer transfer until return demonstration completed. This in-service will include human simulation and a post test demonstration. 2. A list of all hoyer list residents was obtained for the in-service and communicated with the staff with care plan comparison. 3. On 6/7/24 pain assessments on all residents were started by nursing administration to ensure all pain needs were addressed with interventions in place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. Administrator/DON initiated an in-service for all staff on 6/7/24 on incident/accident policy, abuse neglect exploitation. A post-test will be performed with staff over information in-serviced on by administration, and a score of 100% must be achieved. If less than 100%, staff will be reeducated and retest until 100% is achieved. 5. Administrator/DON initiated an in-service for licensed nursing staff on 6/7/24 on incidents and accidents assessments with a focus on ROM status and changes in ROM warranting higher level of care need. An in service with licensed nursing staff regarding the facility fall policy and procedure. A post-test will be performed with staff over information in-serviced on by administration, and a score of 100% must be achieved. If less than 100%, staff will be reeducated and retest until 100% is achieved. 6. Administrator/DON initiated an in-service 1:1 for CNA A and CNA B regarding hoyer lift transfer with return demonstration, and immediate notification either the DON or administrator regarding policy failure identified. Immediate disciplinary action regarding policy and procedure failure will take place with CNA A. 7. Administrator/DON initiated an 1:1 Inservice with LVN Nurse A regarding assessment of a resident post fall with a focus on ROM activity to perform. 8. Administrator and DON were in-serviced on 6/7/24 by Regional Director of Clinical Services on all the policies mentioned above, and to notify regional/corporate staff of ALL falls/incidents, and are to notify regional/corporate staff of any discrepancies. Regional/corporate staff will follow-up on each fall/incident in question and direct with appropriate interventions. If staff are unable to attend any of the in-services, they will be required to complete the in-service before starting their assigned shift. Any agency will be in-serviced prior to the beginning of their shift. Any new hires will be in-serviced on hire, prior to working a shift. The Medical Director was made aware of the Immediate Jeopardy 6/7/24 at 6:49 PM and has been involved in developing the Plan of Removal. These conversations are considered part of the QA process. A QAPI meeting was held on 6/7/24 with attendance of Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Regional Director of Clinical Services, and Regional Director of Operations. This plan was initially implemented 6/7/24 and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is 6/8/24 by 5:00 PM with continuation of oncoming staff and follow-up. Monitoring/Verification of Plan of removal The POR were reviewed as followed. The facility created a binder and numbered each tab in the binder with the completed documentation necessary to fulfill the plan. Sunday 06/09/24 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan 0689 -a hoyer in-service was initiated for all direct care staff and staff were not allowed to return to work unless the hoyer lift training had been completed. -a list of hoyer lift residents were provided and all hoyer lifts would be observed by LVN for the next 7 days. A hoyer lift review would be watched on 6/10/24. The surveyor would for review of competency. This was completed. -In-service on abuse and neglect was initiated with the post test. Completed for all direct care staff. -Admin and DON in-serviced licensed nursing staff regarding ROM status and changes in ROM. A test would be given with a score of 100% or better. -staff would be reviewed and questioned for competency. -needed to check the list of last falls in 90 days to review that interventions listed have been put into place. This was completed. -Completed the in-services for admin and DON on all policies highlighted in POR for 0689 -a hoyer lift Inservice was also completed on 06/08/24 with CNA A and NA B. 1:1. Both were signed and the check list showed a passing score. -hoyer lift list was presented to surveyor. Demonstration was also caught. -Post test was also initiated for hoyer lift training with staff. Monday 06/10/24 Interviews: Interview with RN A at 12:36 p.m., he stated they talked about who to notify if abuse and neglect were suspected and who to look for if you suspect something happened. Things to look for may be bruises and injuries. The abuse coordinator was the Admin and the reporting time was within 2 hours. He stated that they also discussed the full head to toe assessment and to make sure they notify the physician and the family. They did a hoyer lift training as well and he was used as the test person. They trained the aides and made sure they were comfortable with doing a hoyer transfer. He said he didn't learn anything new and he didn't have any issues with it. In an Interview with CNA E at 12:41 p.m., she stated that in the abuse and neglect in-service, they talked about who was the coordinator and to whom did they report. They reported to nurse first, then ADON, DON, and Admin. The abuse coordinator was the Admin. Reportables were anything physical, neglect, money situation or abuse of funds, and verbal. Examples were bruising on the body or anything foreign. From the hoyer training, she covered that the hoyer must always be done with two people, a nurse to monitor and two aides. She was comfortable with the demonstration today and felt that it was good refresher. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with NA C at 12:51 p.m., she stated that for abuse and neglect, they discussed if someone saw someone doing something harmful, immediately report it. The chain of command was nurse, ADON, and DON, then Admin. The abuse coordinator was the Admin. Types were physical, emotional, verbal, and sexual. She explained when a resident fell , they immediately reported it to nurse. From there the Admin and DON, ADON. The nurse checked it out and saw if they could lift them or any issues. If so, they would send them out. If a resident fell , she would wait for a nurse to come and check them. She stated she felt comfortable with the hoyer lift training because she had been doing it since she was [AGE] years old. In an interview with CMA A at 12:58 p.m., he explained that for abuse and neglect, they covered if they noticed abuse and neglect. Types were verbal, sexual, physical, and neglect. If suspected, they would report it to the Admin, who was the abuse coordinator. For falls, they would go to the charge nurse first so they could come and assess the resident before they touched or did anything with them. He stated the hoyer lift training was a refresher and learned that they must always operate the lift with 2 aides and a nurse. He explained that they were not supposed to do a hoyer transfer in the hallways unless it was an emergency. He stated that it was best to do a hoyer transfer in the resident's room so that they could have their privacy. In an interview with LVN A at 11:16 p.m., she said that all forms of suspected abuse were to be reported to the abuse coordinator, the Admin. If a resident [NAME] they were supposed to report it to the DON and she would call the family and the doctor. For fall assessments, they nurses would complete skin checks, vitals, range of motion, and a pain assessment. After that had been completed, aides could pick the resident off of the floor. In the hoyer lift training they covered that they must always operate the lift with 2 aides and a nurse. The resident must be in a sitting position and the colors on the top and bottom of the sling must match up and the chair should be locked. This was a refresher for her. In an interview with CNA F at 1:22 p.m., she stated they covered what staff would do when someone fell . She said they would not move the resident and would wait until the nurse got there and did the vitals. It was not ok to move the resident unless the nurse had checked the vitals and they were ok. If they needed to go to the hospital, then the paramedics would move them. For abuse and neglect, they covered that when they see abuse and neglect, they must report it to the abuse coordinator, the Admin. She gave the example that some different types of abuse were emotional, sexual, physical, mental, or stealing from residents. An example she gave was when she saw an old coworker years ago at a different get hit by a resident and they responded by hitting them back. She reported it immediately. She stated the hoyer lift training was a refresher and learned that they must always operate the lift with 2 aides and a nurse. She explained that they were not supposed to do a hoyer transfer in the hallways and always in their rooms. In an interview with NA D at 12:29 p.m., she explained that the hoyer lift training covered how to position the resident in the hoyer lift. She learned how to operate the hoyer lift controls and brace them in the locked wheelchair. The resident should always be positioned in a siting position in the hoyer lift and there should always be at least 3 people. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Woodlake Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 603 E Plantation Rd Clute, TX 77531	

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	A hoyer lift observation was witnessed on 06/10/24 at 1:33 p.m., with Resident #1, NA C, NA D, CNA E, and RN A. CNA E strapped Resident #1's legs in the harness while she was sitting in the wheelchair. NA C used the controls to lift her slowly up in the hoyer while she was in a sitting position. They moved the wheelchair back and RN A grabbed the back on the sling and adjusted Resident #1 above the bed. She was laid gently in the bed by NA D, who held her legs in a slightly bent position due to her contractures. Resident #1 said she was ok during the transfer and she was not in pain. No concerns with transfer. Tuesday 06/11/24 On Tuesday 06/11/24 from 4:30pm - 6:00pm, calls were made to staff who were on the alternate rotating 12 hour schedule. A total of 14 calls were made from staff who worked the 6am-6pm and the 6pm-6am shift. Seven calls were successful. NA E call at 4:34 p.m., 6am-6pm shift She stated for abuse and neglect, they covered the bruising and if they saw any bruising, the way someone talked to a resident, she should report immediately after witnessing it to the abuse coordinator. Different types of abuse were verbal, physical, and neglect. When witnessing a fall, staff immediately reported to charge nurse and would not mess with them. The charge nurse would check the vital signs immediately after the fall. Staff only moved the resident after the charge nurse gave them the permission to move them. For the hoyer lift, they were to make sure the residents were in a sitting position and not laying in the hoyer lift. Two CNA's and a charge nurse should be present. She learned that residents should be in a sitting position. CNA C called at 4 ;42 p.m., 6am-6pm shift, PRN Said she had not been to work since the following week and had not covered the abuse and neglect trainings yet but she would be returning to work the following day. For the hoyer lift training, she had to demonstrate how to do it and how to put it on. She would have the resident in a sitting chair position. There should be two people present during a hoyer transfer. When a resident fell , she would leave them there and go get the nurse. The nurse would examine them and they would not be able to lift them up or touch them until after they has been examined after a fall. CMA C called 4:59 p.m., 6a-6p For abuse and neglect they covered about reporting if they saw anything, like from another staff or another resident, they have to report it immediately. The abuse coordinator was the Admin and the different types of abuse were hitting, kicking, biting and scratching. For falls, they were supposed to get the nurse immediately and don't move them. They left them there and asked if they were ok. The nurse needed to check and they have to makes sure the resident was ok and have someone watching. For hoyer training, there should always be two people with a hoyer lift. When they use the sling, all the colors should be matching so that the resident was balanced correctly and in a sitting position. CNA G called at 6:44 p.m., 6am- 6pm shift (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	They covered what was abuse and neglect and the importance in making sure everybody was in communication and documenting. The priority was to make sure residents were safe and secure. Some examples were mental, physical, and financial. A real time example would be if a resident asked for some water or something to drink and staff ignored it and said it was not their job. The abuse coordinator was the Admin and all abuse should be reported immediately. When a resident fell , don't touch them and call the nurse. Let them get viewed and don't touch them until the nurse said it was ok. Aides do an incident report and follow up. For the hoyer lift, staff cannot do a hoyer transfer in the hallway and it had to be 2 persons or more. All of the colors in the straps have to match, the wheelchair must be locked, and the person must be trained to do the hoyer lift. She explained that she was comfortable with the training and it was refresher. She explained the Kardex was used to let you know what is happening with the resident, where their room was, what their plan of care was, and what we have to chart for. To find the Kardex she would sign in, got to the POC, go to different labels, and find the chart that said Kardex and open it up. The Kardex showed things about the resident like meals, blood pressure, and gave some familiarity with what was going on with the resident CNA H called at 5:18 p.m., 6am-6pm shift, PRN The abuse and neglect training covered the verbal, physical, financial, mental, and emotional. The abuse coordinator was the administrator and an example would be if she saw someone saying a resident couldn't spend their money or they couldn't have their own belongings. If a resident fell , staff must let a charge nurse know immediately and don't pick them up. Staff can pick the resident up after all the vitals, the nurse checked them, and[TRUNCATED]