STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675330	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Radford Hills Healthcare Center	725 Medical Dr Abilene, TX 79601

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interviews and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 2 (Resident #2 and Resident #4) of 10 residents reviewed for baseline care plans. The facility failed to ensure that Resident #2 had baseline care plan developed within 48 hours after being admitted to the facility on [DATE]. The facility failed to ensure that Resident #4 had a baseline care plan developed within 48 hours after being admitted to the facility on [DATE]. These failures placed the residents at risk of not having continuity of care to safeguard against adverse events that are most likely to occur right after admission. Findings included: Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted to facility on 03/05/2024 with diagnoses to include: repeated falls, muscle weakness, anxiety, and depression. Review of Resident #2's Quarterly MDS assessment, dated 03/20/2024, revealed BIMS score (09) which indicated moderate cognitive impairment. Review of Resident #2's clinical record revealed no evidence of a baseline care plan. Review of Resident #4's electronic face sheet revealed a [AGE] year-old male admitted to facility on 03/22/2024 with diagnoses to include: kidney disease, heart disease, and amputation. Review of Resident #4's Admission MDS assessment, dated 03/25/2024, revealed BIMS score (15) which indicated no cognitive impairment. Review of Resident #4's clinical record revealed no evidence of a baseline care plan. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/05/2024 at 10:45 am, the DON stated there had been some confusion and miscommunication regarding care plans and staff's individual responsibilities. She stated she thought the floor nurses were responsible for initiating baseline care plans. The DON stated Resident #2's baseline care plan was started by herself but for some reason the document did not submit, and she was not aware. The DON stated that she had recently learned that the facility staff did not know they could complete baseline care plans or add to the comprehensive care plans and thought that only the DON could. The DON stated she was ultimately responsible to ensure completion and accuracy of care plans. During an interview on 04/05/2024 at 3:20 pm, the MDS Coordinator stated she was not responsible for baseline care plans. She stated the DON and ADON were responsible for completing baseline care plans. Record review of facility policy labeled Care Plans-Baseline revised December 2016 revealed: a baseline plan of care to meet the president's immediate needs she'll be developed for each resident within 48 hours of admission. To assure that the residents immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission. The interdisciplinary team will review the health care practitioner's orders (dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the residents immediate care needs including but not limited to initial goals based on admission orders, physician orders, dietary orders, therapy services, social services . The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to the initial goals of the resident, a summary of the resident's medications and dietary instructions, any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45732 Based on interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan based on assessed needs with measurable objectives that have the ability to be evaluated or quantified to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #2 and Resident #3) of 10 residents reviewed for comprehensive person-centered care plans. The facility failed to develop care plans based on the assessed needs with measurable objectives and timeframes in area of risk for falls for Resident #2. The facility failed to develop care plans based on the assessed needs with measurable objectives and timeframes in area of risk for falls for Resident #3. This failure could place the residents at risk for decreased quality of life and not having their needs met. Findings include: Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted to facility on 03/05/2024 with diagnoses to include: repeated falls, muscle weakness, anxiety, and depression. Review of Resident #2's Quarterly MDS assessment, dated 03/20/2024, revealed BIMS score (09) which indicated moderate cognitive impairments and Section J Health Conditions revealed: 0 falls since admission or prior assessment. Review of Resident #2's Comprehensive Care Plan, initiated 03/09/2024, revealed no evidence of falls or fall risk. Review of Resident #2's Morse Fall Scale dated 03/06/2024 at 12:00 PM, signed by LVN D revealed score 55% indicating high fall risk. Review of the Facility Event Summary Report from 02/25/2024-03/27/2024, revealed Resident #2 had an unwitnessed fall on 03/18/2024 at 8:34 am and 03/25/2024 at 05:43 am. Review of Resident #2's electronic progress note, dated 03/18/2024 04:49 PM, signed by LVN E, revealed: Heard resident yelling Help x4 staff went rushing into room resident noted to be laying on back side assessment completed VS obtained Neuros initiated ROM x 4 extremities without limitations x1 staff assisted resident to bed denies hitting head no visible injuries noted notified [Facility Medical Director] notified DON notified RP verbalized understanding denies pain denies needs care is ongoing. Further review of electronic progress notes did not reveal any documented evidence of fall on 03/25/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 Review of Resident #3's electronic face sheet revealed a [AGE] year-old female admitted to facility on 02/24/2023 with diagnoses to include: Hemiplegia, unspecified affecting right dominant side (paralysis), muscle weakness, anxiety, and lack of coordination. Review of Resident #3's Quarterly MDS assessment, dated 01/04/2024, revealed BIMS score (13) which indicated no cognitive impairments and Section J Health Conditions revealed: 0 falls since admission or prior assessment. Review of Resident #3's Comprehensive Care Plan, last reviewed 03/19/2024, revealed no evidence of falls or fall risk. Review of Resident #3's Morse Fall Scale dated 03/03/2024 at 12:34 AM, signed by LVN H revealed score 70% indicating high fall risk. Review of the Facility Event Summary Report from 02/25/2024-03/27/2024, revealed Resident #3 had an unwitnessed fall on 03/08/2024 at 04:21 am. Review of Resident #3's electronic progress note, dated 03/08/2024 02:47 AM, signed by LVN I, revealed: Resident's roommate told this nurse that resident was sitting on the floor. Found resident sitting on the floor in her bathroom next to wheelchair. Resident transferred to wheelchair. Vitals taken. No injuries related to fall. Resident denies pain. During an interview on 04/05/2024 at 10:45 am, the DON stated there had been some confusion and miscommunication regarding care plans and staff's individual responsibilities. She stated she was under the impression that the floor nurses were to update care plans with acute and new issues. She stated she thought the floor nurses were responsible for initiating baseline care plans. The DON stated the MDS coordinator was then responsible for completing the comprehensive care plan after completing the MDS. The DON stated Resident #2's baseline care plan was started by herself but for some reason the document did not submit, and she was not aware. The DON stated the baseline care plan would have triggered the fall risk and then the MDS coordinator would have added the care area of fall risk to the comprehensive care plan. The DON stated that she had recently learned that the facility staff did not know they could complete baseline care plans or add to the comprehensive care plans and thought that only the DON could. The DON stated that all acute concerns and new falls should be added to the comprehensive care plan with appropriate interventions after a resident falls and with each fall thereafter. The DON stated Resident #2 and Resident #3 should have had fall risk with interventions in place on the care plan since they were both high fall risk and had had falls in the facility. The DON stated she was ultimately responsible to ensure completion and accuracy of care plans. During an interview on 04/05/2024 at 3:20 pm, the MDS Coordinator stated she was not responsible for baseline care plans, acute issues, or any new areas of concerns. She stated she only added care areas to the comprehensive care plan that were triggered from the MDS completion. She stated that when completed quarterly care plan reviews, she only ensured that all care areas triggered by MDS were in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/05/2024 at 3:30 PM, the administrator stated she would have a meeting and address the care plan miscommunication. She stated the facility had a morning clinical meeting every day and at that time all new concerns including falls should be addressed and added to the care plan. The Administrator did not state who would be responsible for this responsibility. She stated it was ultimately her responsibility to ensure that care plans were accurate and being completed correctly. During an interview on 04/05/2024 at 3:40 pm, the Director of Clinical Operations she stated that comprehensive care plans were a complete overview are residents care and needs. She stated the MDS Coordinator should not have just added triggered care areas but should have completed a comprehensive thorough overview of the resident and all concerns when performing a care plan review. She stated education would be provided. Review of facility's policy Care Plans, Comprehensive Person-Centered revised December 2020 revealed: The comprehensive, person-centered care plan will: A. include measurable objectives and time frames; 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; . E. Include the resident's stated goals upon admission and desired outcomes G. Incorporate identified problem areas; H. Incorporate risk factors associated with identified problems . Reflect treatment goals, timetables and objective 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 residents functional status and or functional ; N. Enhance the optimal functioning of the resident by focusing on a rehabilitative program, and O. Reflect current recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after careful data gathering, proper sequence of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 45732 Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 3 (Resident #1, Resident #2, and Resident #3) of 6 residents reviewed for multiple falls. The facility failed to implement appropriate interventions for Resident #1 to prevent 5 falls within 19 hours from [DATE] at 12:30pm to [DATE] at 7:30am, that lead Resident #1's Family Member B calling 911, which resulted in hospitalization with diagnoses of subarachnoid hemorrhage (brain bleed) and L3 fracture (lumbar spine fracture) which resulted in death on [DATE]. The facility failed to identify fall risk or implement any interventions in the Plan of Care for Resident #2 who was a known fall risk and had falls on [DATE] and [DATE]. The facility failed to identify fall risk or implement any interventions in the Plan of Care for Resident #3 who was a known fall risk and had fall on [DATE]. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 2:07 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm, due to the facility's need to continue to monitor the implementation and effectiveness of their corrective systems. These failures could place the residents at risk for falls, serious injuries, hospitalization s, and death. Findings include: Resident #1 Review of Resident #1's electronic face sheet revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses to include: heart disease, COPD (lung disease), intervertebral disc degeneration of lumbar region, anxiety, and syncope (fainting) & collapse. Review of Resident #1's electronic records revealed no evidence of completed MDS and Baseline Care Plan. Review of Resident #1's referral paperwork from Hospice to the facility, dated [DATE], revealed: Brief Narrative Statement: . In the last six months, this patient has continued to show decline as evidenced by increased weakness. He continues to have falls related to episodes of syncope. Review of Resident #1's electronic progress note, dated [DATE] 11:50 AM, signed by ADON, revealed: Resident arrived to the facility via facility van, accompanied by family and hospice nurse. resident was weighted on arrival and was offered lunch but refused. resident is not happy to have a roommate and is trying to leave facility. resident's [family member B] is sitting with him to help residents' anxiety. resident was showed around the facility and around his room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's electronic progress note, dated [DATE] 12:30 PM, signed by ADON, revealed: Resident was found on the floor by this nurse and the residents [family member B]. Resident was helped back to his wheelchair with the help of a gait belt and two other aides. resident was then brought to the nurse's station and was accompanied by [family member B]. Residents' family member B has asked about restraints and sedatives. nurse educated that restraints are not allowed and that the resident would not be sedated. Review of Resident #1's Morse Fall Scale dated [DATE] at 1:51 PM, signed by ADON revealed score 75% indicating high fall risk. Review of Resident #1's electronic physicians orders revealed: alprazolam (Xanax- sedative for anxiety)) 2mg 1 tablet oral twice a day 12:00 pm- 2:00 pm, 8:00 pm- 10:00 pm; tramadol (narcotic for pain) 50mg 1 tablet oral twice a day 12:00 pm, 9:00 pm; tramadol 50mg 2 tablets twice a day 5:00 am, 4:00 pm. Further review of electronic physicians' orders revealed: tramadol 50 mg 1 tablet oral immediately ordered on [DATE] at 2:18 am and alprazolam 2 mg 1 tablet oral immediately ordered on [DATE] at 2:00 am. According to the Drugs.com website, https://www.drugs.com accessed on [DATE] revealed, Xanax may cause some unwanted effects including: clumsiness or unsteadiness, difficulty with coordination, and lightheadedness. According to the Drugs.com website, https://www.drugs.com accessed on [DATE] revealed, Tramadol may cause some unwanted effects including: change in walking and balance, dizziness, and fainting. Review of Resident #1's electronic MAR, dated [DATE], revealed Xanax 2mg was administered at 2:14 pm on [DATE]. Further review of electronic MAR revealed tramadol 50mg 2 tablets was administered between 4:, d+[DATE]:00 pm on [DATE]. Review of Resident #1's electronic progress note, dated [DATE] 06:56 PM, signed by ADON, revealed: resident had a fall hospice was notified awaiting call back and resident's family member C was notified. Residents' family member B did not answer the phone at this time. Further review of progress notes, dated [DATE] 6:59 PM, revealed: spoke with hospice and she will be on the way. resident is at the nurse's station and is be watched closely. Review of Resident #1's electronic progress note, dated [DATE] 07:00 PM signed by LVN A, revealed: This nurse was called to the dining room by the laundry staff. upon walking in, the resident was found sitting on the floor leaning up against the wall. the patient had a head laceration to the right side of the forehead. another LVN on shift went to get proper supplies to apply pressure to the wound, while this nurse checked vitals. pt was assisted back to the chair with the assistance of 3 staff. This nurse took the resident to the treatment room and continued to hold pressure. Hospice was notified and is sending a nurse out. This nurse chose to apply an ice pack to reduce swelling until hospice arrives. Review of Resident #1's electronic progress note, dated [DATE] 07:02 PM, signed by ADON, revealed: nurse spoke DON she is aware of the fall with head injury. nurse has spoken with [Facility Medical Director] he is aware and asked to be updated with what hospice nurse decides. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Post-Fall Progress Note, dated [DATE] 08:54 PM, (regarding fall at 6:56 pm on [DATE]) signed by LVN A, revealed: Post-Fall Follow-up: . Interventions: Bed in Low Position, Toileting Offered, Other 2: call light within reach Resident Response to Fall Interventions: Current Interventions are Effective. Review of Resident #1's electronic progress note, dated [DATE] 08:59 PM, signed by LVN A, revealed: Hospice in to see resident. resident's forehead was cleaned and steri-striped and covered with a bandage. no new orders at this time. neuros are continued. Review of Resident #1's electronic MAR, dated [DATE], revealed tramadol 50 mg 1 tablet and Xanax 2mg 1 tablet was administered at 9:37 pm on [DATE]. Review of Resident #1's electronic progress note, dated [DATE] 02:07 AM, signed by LVN B, revealed: Resident found in bathroom on floor with head in toilet, noted to have a new head lac about 3cmx0.5cm on right eyebrow. Applied pressure until bleeding stopped. Assisted resident back into bed, vitals taken at this time and within normal limits besides residents BP which was ,d+[DATE] and instructed him to use call light if he needs assistance. Also lowered bed into lowest position and turned ion bathroom light for more visibility. Hospice notified of fall and injury, and also that resident had persistent high BP and Hospice Nurse gave an order for a one-time Xanax 2mg po. Given and tolerated well. Attempted to notify residents [family member C] and left a voicemail, attempted to call [family member B], and went straight to voicemail, awaiting a call back. Review of Resident #1's electronic MAR, dated [DATE], revealed tramadol 50 mg 1 tablet and Xanax 2mg 1 tablet was administered between 02:,d+[DATE]:00 am on [DATE]. Review of Resident #1's Post-Fall Progress Note, dated [DATE] 02:27 AM, signed by LVN B, revealed: Interventions: Bed in Low Position, Toileting Offered, Bell to Ring for Assistance When Out of Room, Night Light added in Bathroom. Resident Response to Fall Interventions: Current interventions are Somewhat Effective. Review of Resident #1's electronic progress note, dated [DATE] 04:03 AM, signed by LVN B, revealed: Resident found in bathroom floor on back. No new injuries noted at this time. Assisted resident back to bed and instructed to use call light for assistance. Resident then rolled towards the wall and started snoring. This nurse notified hospice and [Facility Medical Director] of this fall neither had any new orders. Review of Resident #1's Post-Fall Progress Note, dated [DATE] 04:04 AM, signed by LVN B, revealed: Interventions: Bed in Low Position, Toileting Offered, Non-Skid Slippers, Bell to Ring for Assistance When Out of Room, Night Light added in Bathroom. Resident Response to Fall Interventions: Current Interventions are Not Effective. Referred to Interdisciplinary Team for Further Recommendations. Review of Resident #1's electronic MAR, dated [DATE], revealed tramadol 50 mg 2 tablets was administered at 4:10 am on [DATE]. Review of the Facility Event Summary Report revealed Resident #1 had an unwitnessed fall in his bedroom on [DATE] at 07:00 am. Review of electronic progress notes revealed no evidence of documentation related to fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's electronic progress note, dated [DATE] 07:00 AM, signed LVN C, revealed: Resident very restless and continues to try and get out of wheelchair. Multiple hematomas to midline of forehead. No bruising noted at this time. 2cm skin tear to right mid forehead. Hospice called this AM to attempt to get resident PRN anxiety medication. Hospice to call back with further instruction. Review of Resident #1's electronic progress note, dated [DATE] 07:45 AM, signed by LVN C, revealed: Called residents [family member C] this AM to notify her of behavior and changes to Resident #1. Residents' [family member C] voiced that he had been very difficult to take care of at home and that he kept having repetitive falls and that is why we brought him to you guys. This nurse acknowledged that he had several falls since admission yesterday afternoon and that this nurse was attempting to get medication changes from hospice to hopefully keep his anxiety under control. Residents' [family member C] voiced understanding and agreed that Resident #1 needed the med changes. No new orders at this time. Review of Resident #1's electronic progress note, dated [DATE] 11:30 AM, signed by DON, revealed: Hospice in facility with new order for Ativan .5mg 1 or 2 tabs every 4 hours for anxiety. Resident #1 placed on one-to-one supervision @ 0740 this AM due to increased attempts to get out of wheelchair. Dose of Ativan administered immediately once received at 1100 am. Resident appeared content once one to one was put into place. Resting peacefully in chair with no attempts to get out of chair. Review of Resident #1's hospital clinical record, dated [DATE], revealed: Admitting Diagnosis: Subarachnoid hemorrhage (brain bleed) and L4 vertebral fracture. Resident is going to go to inpatient hospice unit for further care. During an interview on [DATE] at 11:55 am, Residents #1's family member A stated Resident #1 was admitted to the facility under hospice services because he was falling too much at home. Resident #1's Family member C could not take care of him. He stated the facility was fully informed as to Residents #1's fall risk and it was discussed thoroughly. He stated the facility called Resident #1's Family member C at 1:30 am on [DATE] and left a voicemail stating they needed to update her on Resident #1's condition. He stated Resident #1's Family member C tried to return the phone call from 6:30 am until 9:30 am on [DATE], with no answer from the facility. He stated Resident #1's Family member B arrived at the facility at 12:30 on [DATE] and saw Resident #1, with multiple lacerations and bruises to his forehead and top of head, and very lethargic and confused she called 911 and Resident #1 left in an ambulance and went to the emergency room . He stated Resident #1 was admitted to inpatient hospice the next day. He stated resident was diagnosed with brain bleed and L4 fracture. During an interview on [DATE] at 12:10 pm, Resident's #1's family member B stated Resident #1 had fallen while she was in the facility, and she spoke with the facility concerning residents' risk for falls. She stated when Resident #1 was admitted he could communicate. She stated when she arrived at the facility at 12:20 pm on [DATE], Resident #1 was lethargic and mumbling. She said Resident #1's Family member C was only contacted one time at 1:30 am on [DATE] regarding the falls. She stated Resident #1's Family member C spoke to a nurse who was extremely rude at 7:00 am who stated Resident #1 had fallen 12 times and the facility could no longer take care of him. She stated when she arrived at the facility at 12:30 pm an [DATE] and saw Resident #1 with multiple lacerations and bruises to his forehead and top of head, and very lethargic and confused Resident #1 was, she called 911. Resident #1's Family member B stated she was not notified of any of the falls, and she felt as if the facility should have called her when Resident #1's Family member C did not answer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 12:40 pm, the DON stated Resident #1 was admitted on Friday [DATE] from home with hospice services. She stated the facility was not aware of the extent of residents falls and behaviors. She stated Resident #1 fell right after arriving to the facility while the family was present. She stated the family then informed her of the extent of resident's multiple falls. She stated the family was requesting 1:1 supervision and she informed the family that the facility could not provide that type of service. She stated she was notified of the fall Friday evening at 6:45 pm and notified the medical director. She stated the medical director originally stated to send him to the emergency room but after realizing the resident was on Hospice services, he told her to contact hospice and let them take the lead. The DON stated she was notified of the fall at 7:00 am on [DATE], and that the resident had had multiple falls through the night, and she placed the resident on 1:1 supervision at that time. During an interview on [DATE] at 12:50 pm, the ADON stated Resident #1's family wanted 1:1 supervision after Resident #1's first fall at 12:30 pm on [DATE], and she informed the family that the facility was not capable of providing that service. The ADON stated that resident flipped over in his wheelchair and landed headfirst possibly causing the first top of the head bruise and swelling at 6:45 pm on [DATE] The ADON stated intervention put in place was sitting resident at the nurses' station and keeping him in line of sight. She stated she was notified of every fall. The ADON stated resident was not at the nurse's station or in line of sight when he fell in the dining room. She said staff were passing trays and could not continuously monitor him. She stated after Resident #1's fall at 6:45 pm on [DATE], the intervention she put in place was resident be placed back in line of sight at the nurses' station. The ADON stated the forehead abrasion was caused by resident hitting the wall and he had glasses on. The ADON stated after the fall at 7:00 am on [DATE], she decided to place the resident on 1:1 supervision. During an interview on [DATE] at 4:30 pm, LVN B stated she arrived for her shift at 6:00 pm on [DATE], and the facility was chaotic. She stated there were too many nurses scheduled and not enough CNAs. She stated no one knew who was responsible for which residents. She stated Resident #1 was not at the nurse's station when she arrived. She stated Resident #1 fell in the dining room around 6:45 pm on [DATE], but she didn't handle the fall as she had not gotten report yet. The LVN stated she was given the medication cart keys and told what hall to pass medications on and she did not receive a report. She stated around 8:00 pm on [DATE], she was told Resident #1 had had 2 falls but was not given a report as to his condition or any increased supervision or interventions. She stated Resident #1 was falling asleep in his wheelchair around 1:00 am on [DATE] and was placed in bed in low position. She stated she notified family, hospice, and ADON of each fall and was not given any extra instructions regarding fall interventions. During an interview on [DATE] at 9:00 am, Resident #1's family member A stated Resident #1 had passed away that morning on [DATE], on hospice services. He stated the justice of the peace officer stated cause of death was subarachnoid hematoma from falls. During an interview on [DATE] at 9:00 am, the DON stated she should have identified the extent of Resident #1's fall risk after the initial fall and should have immediately initiated a care plan with more appropriate interventions. She stated she was not notified of the multiple falls throughout the night until she arrived the next morning. The DON stated all nurses on shift during the incidents were agency nurses who were new to the facility and were not aware of her expectations. She stated she expected her nurses to notify her of each incident at the time they occurred. She stated she should have been more aggressive with the admission and researched the resident prior to admission. (continued on next page)

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	675330	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Radford Hills Healthcare Center	725 Medical Dr Abilene, TX 79601

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interview on [DATE] at 10:00 am, the Administrator stated she was not aware of Resident #1's fall risk prior to admission. She stated she did not see the referral note regarding falls because it was in a little section at the bottom. She stated placing Resident #1 at the nurse's station was not really an appropriate intervention due to the lay out of the nurse's station. The Administrator stated you could not see the resident from every angle of the nurse's station and most staff were not at the nurse's station because they were working up and down the halls. The Administrator stated educating Resident #1 on the use of the call light was not an appropriate intervention due to the resident being medicated with sedatives and having an impaired cognitive status. She stated she planned on educating her staff of implementing more appropriate interventions. Resident #2 Review of Resident #2's electronic face sheet revealed a [AGE] year-old female admitted to facility on [DATE] with diagnoses to include: repeated falls, muscle weakness, anxiety, and depression. Review of Resident #2's Quarterly MDS assessment, dated [DATE], revealed BIMS score (09) which indicated moderate cognitive impairments and Section J Health Conditions revealed: 0 falls since admission or prior assessment. Review of Resident #2's Comprehensive Care Plan, initiated [DATE], revealed no evidence of falls or fall risk. Review of Resident #2's Morse Fall Scale dated [DATE] at 12:00 PM, signed by LVN D revealed score 55% indicating high fall risk. Review of the Facility Event Summary Report revealed Resident #2 had an unwitnessed fall on [DATE] documented at 8:34 am and [DATE] documented at 05:43 am. Review of Resident #2's electronic progress note, dated [DATE] 04:49 PM, signed by LVN E, revealed: Heard resident yelling Help x4 staff went rushing into room resident noted to be laying on back side assessment completed VS obtained Neuros initiated ROM x 4 extremities without limitations x1 staff assisted resident to bed denies hitting head no visible injuries noted notified [Facility Medical Director] notified DON notified RP verbalized understanding denies pain denies needs care is ongoing. Further review of electronic progress notes did not reveal any documented evidence of fall on [DATE]. Observation of Resident #2 on [DATE] at 2:30 pm, sitting in wheelchair in dining room with houseshoes on her feet. No issues noted. Resident #3 Review of Resident #3's electronic face sheet revealed a [AGE] year-old female admitted to facility on [DATE] with diagnoses to include: Hemiplegia, unspecified affecting right dominant side (paralysis), muscle weakness, anxiety, and lack of coordination. Review of Resident #3's Quarterly MDS assessment, dated [DATE], revealed BIMS score (13) which indicated no cognitive impairments and Section J Health Conditions revealed: 0 falls since admission or prior assessment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #3's Comprehensive Care Plan, last reviewed [DATE], revealed no evidence of falls or fall risk. Review of Resident #3's Morse Fall Scale dated [DATE] at 12:34 AM, signed by LVN H revealed score 70% indicating high fall risk. Review of the Facility Event Summary Report revealed Resident #3 had an unwitnessed fall on [DATE] documented at 04:21 am. Review of Resident #3's electronic progress note, dated [DATE] 02:47 AM, signed by LVN I, revealed: Resident's roommate told this nurse that resident was sitting on the floor. Found resident sitting on the floor in her bathroom next to wheelchair. Resident transferred to wheelchair. Vitals taken. No injuries related to fall. Resident denies pain. Observation of Resident #3 on [DATE] at 2:40 pm, resting in bed in high position. Room appeared cluttered and wheelchair was beside residents bed. During an interview on [DATE] at 10:45 am, the DON stated there had been some confusion and miscommunication regarding care plans and staff's individual responsibilities. She stated she was under the impression that the floor nurses were to update care plans with acute and new issues. The DON stated the MDS coordinator was then responsible for completing the comprehensive care plan after completing the MDS. The DON stated Resident #2's baseline care plan was started by herself but for some reason the document did not submit, and she was not aware. The DON stated the baseline care plan would have triggered the fall risk and then the MDS coordinator would have added the care area of fall risk to the comprehensive care plan. The DON stated that she had recently learned that the facility staff did not know they could complete baseline care plans or add to the comprehensive care plans and thought that only the DON could. The DON stated that all acute concerns and new falls should be added to the comprehensive care plan with appropriate interventions after a resident falls and with each fall thereafter. The DON stated Resident #2 and Resident #3 should have had fall risk with interventions in place on the care plan since they were both high fall risk and had had falls in the facility. The DON stated she was ultimately responsible to ensure completion and accuracy of care plans. During an interview on [DATE] at 3:20 pm, the MDS Coordinator stated she was not responsible for acute issues or any new areas of concerns. She stated she only added care areas to the comprehensive care plan that were triggered from the MDS completion. She stated that when completed quarterly care plan reviews, she only ensured that all care areas triggered by MDS were in place. During an interview on [DATE] at 3:30 PM, the administrator stated she would have a meeting and address the care plan miscommunication. She stated the facility had a morning clinical meeting every day and at that time all new concerns including falls should be addressed and added to the care plan. The Administrator did not state who would be responsible for this responsibility. She stated it was ultimately her responsibility to ensure that care plans were accurate and being completed correctly. During an interview on [DATE] at 3:40 pm, the Director of Clinical Operations stated that comprehensive care plans were a complete overview of resident's care and needs. She stated the MDS Coordinator should not have just added triggered care areas but should have completed a comprehensive thorough overview of the resident and all concerns when performing a care plan review. She stated education would be provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy titled, Falls and Fall Risk Managing, revised [DATE], revealed in part: Policy Statement: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of the facility's policy Care Plans, Comprehensive Person-Centered revised [DATE] revealed: The comprehensive, person-centered care plan will: A. include measurable objectives and time frames; 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; . E. Include the resident's stated goals upon admission and desired outcomes G. Incorporate identified problem areas; H. Incorporate risk factors associated with identified problems . Reflect treatment goals, timetables and objective 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 residents functional status and or functional ; N. Enhance the optimal functioning of the resident by focusing on a rehabilitative program, and O. Reflect current recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after careful data gathering, proper sequence of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified on [DATE] at 2:07 pm that an Immediate Jeopardy was identified, and a Plan of Removal was requested at that time. The Administrator was provided with the IJ template on [DATE] at 2:07 pm. The following Plan of Removal was accepted on [DATE] at 11:24 am and included: Plan of Removal: 689: Accidents, Hazards, Supervision & Devices Failure Statement: Resident #1 had 5 falls within 19 hours until the facility implemented 1:1 supervision from [DATE] at 12:30pm to [DATE] at 7:30am. All residents who currently reside at the facility that are fall risks can be affected by this deficient practice and any future admissions that have a history of falls. Action: Admission Policy and Fall Policy reviewed by Chief Clinical Officer. Current policies do not require any changes at this time. Charge Nurses, CNAs, Administration to be educated on Admission Policy and Fall Policy. Person(s) Responsible: Chief Clinical Officer Date: Start: [DATE] End: [DATE]. Action: Review all residents fall risk assessments to ensure they are updated and accurately reflect the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: Start: [DATE] End: [DATE]. Action: Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Designee will review care plans for the residents that are triggering as fall risks and place resident centered interventions in the care plans to attempt to avoid a repeat fall. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, MDS Coordinator, and/or Designee Date: Start: [DATE] End: [DATE]. Action: Administrator, Director Nursing, and Admissions Coordinator educated regarding obtaining fall risk information prior to admission or at admission in order to accurately perform a fall risk assessment and to ensure resident centered interventions are in place to attempt to prevent falls and communication to the nursing staff on residents being admitted that are fall risks and interventions being initiated. Person(s) Responsible: Director of Clinical Practice Date: Start: [DATE] End: [DATE]. Action: Educate Charge Nurses and CNAs over resident person-centered interventions for falls. Education to include what to do if a resident hits their head and/or cannot voice if they hit their head (initiate neuro checks per policy, notify MD, watch for changes from baseline, etc.) Education to include notifying the MD, Director of Nursing and/or Assistant Director of Nursing, and/or the Administrator with multiple falls on a shift/day. Test will be distributed to evaluate the effectiveness of the education. All Charge Nurses, permanent and temporary, will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: Start: [DATE] End: [DATE]. Action: Educate CNAs and Nurses on resident profile that will alert staff of a resident that is a fall risk, interventions will also be located in the resident profile located in the electronic medical record. CNAs and Charge Nurses will complete a return demonstration on pulling the resident profile and where to view interventions. Educate CNAs and Charge Nurses over the definition of line of sight which is within eyesight of a staff member. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All CNAs and Charge Nurses, permanent and temporary, will be educated prior to working their next shift. Person(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date: Start: [DATE] End: [DATE]. Action: A review of all admissions for potential fall risk will occur prior or at admission. These will be documented x4 weeks to include: Name of Admission, Date of Admission, History of Falls: Y or N, If yes- Interventions to Immediately Occur Upon Admission, CP Reflecting Interventions. Fall risk assessments are completed upon admission, if a resident triggers as a fall risk a care plan will be initiated with person centered interventions. Person(s) Responsible: Administrator and Director of Nursing Date: Start: [DATE] End: [DATE]. Action: Ad hoc QAPI to inform Medical Director of the IJ template for 689 and to educate the medical director that he/she will be consulted regarding all residents, including hospice residents. Person(s) Responsible: Administrator Date: Start: [DATE] End: [DATE]. Monitoring of the facility's Plan of Removal through observations, interviews, and record reviews from [DATE] at 11:25 am through [DATE] at 3:10 pm revealed: Reviewed in-service information and signature sheets for in-service titled, Falls and Fall Risk, Managing. Information included: admission policies, fall policies, and admission checklist. Verified 20 employee signatures. Comparison of schedule from [DATE]- [DATE] including day and night shift revealed all scheduled staff were educated prior to working their next shift. Random interviews with 2 dayshift nurses and 2 dayshift CNAs verified understanding of in-service. Random phone interviews with 2 nightshift nurses and 2 nightshift CNA's verified understanding of in-service titled, Falls and Fall Risk, Managing. During interview with the DON and Director of Clinical Operations stated new Morse Fall Risk assessments were performed on all residents. The facility identified a total of 35 high fall risk residents. During this process 15 residents went from a low fall risk to a high fall risk. Verified list of residents who changed from low fall risk to high fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Random record reviews revealed at least 5 residents had a new Morse Fall Risk Assessment performed on [DATE] which changed resident from a low fall risk to a high fall risk. Further record review of these 5 residents revealed new resident centered interventions in the care plans to attempt to avoid a repeat fall. Reviewed in-service information and signature sheets for in-service given by Director of Clinical Operations to Administrator, Director Nursing, and Admissions Coordinator stating: The Admission Coordinator/Dire[TRUNCATED]