STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675431	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Oak Health and Rehabilitation Center	101 Reese Dr Red Oak, TX 75154

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44700 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse or neglect, including injuries of unknown source, were e reported immediately, or not later than 24 hours to other officials (including to the State Survey Agency) in accordance with State law through established procedures for one (1) resident (Resident #1) of seven (7) residents reviewed for abuse and neglect. The facility failed to report Resident #1's fall on [DATE], which resulted in a head injury, in a timely manner to the State. This failure could place residents at risk for abuse, neglect, and a decreased quality of life. Findings included: Review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included Chronic Kidney Disease, Dementia, Anemia (low iron in blood), Hyperlipidemia (high cholesterol), Glaucoma (eye disorder that clouds vision) and muscle weakness. Review of Resident #1's admission MDS assessment dated [DATE] reflected a BIMS score of zero (0) suggesting severe cognitive impairment. Review of MDS section Functional Abilities and Goals reflected resident used a wheelchair for a mobility device. Further review of this MDS section reflected resident needed substantial/maximum assistance for wheelchair mobility to wheel 50 feet with two turns. Review of Resident #1's undated care plan reflected the problem [Resident #1] is high risk for falls r/t DX Dementia with interventions be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. Ensure a safe environment, floors even and free from spills or clutter, adequate light, bed in low position, personal items within reach, maintain a clear pathway, free of obstacles. Further review of care plan reflected another problem [Resident #1] has had an actual fall r/t Cognitive impairment [DATE] fall w/o injury, [DATE] fall w/o injury, [DATE], fall w/injury with interventions Falling star program , place fall mat at bedside, PT/OT consult for strength and mobility as needed, [DATE]: sent to ER for further eval . Review of Resident #1's fall assessment dated [DATE], reflected a score of 19 indicating Resident #1 was at High Risk for falls. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's progress notes dated [DATE] at 9:41 pm but effective [DATE] at 7:45 pm by LVN A reflected SN down hall passing medication and was called by kitchen staff that patient was in floor near nursing station. When SN arrived at nursing station patient was noted to be on floor near wheelchair. SN and other nursing staff removed patient from floor after assessment completed and patient noted to have a hematoma to the right forehead with scant blood at site. Patient transferred to room via wheelchair. While in room adjusting patient in bed patient noted to have closed eyes and when called by name, patient was unresponsive and showing no sign of life. 911 called and SN with assist of other nursing staff started CPR. Paramedics arrived and took over CPR administration . During an interview on [DATE] at 4:20 pm, the DON stated she was familiar with Resident #1's fall incident on [DATE]. She stated she knew Resident #1 was a fall risk and had seen her at the nurse's station. She stated, I saw her up there often. She stated staff often brought her up to the nurse's station in her wheelchair, for safety - to keep eyes on her. The DON stated she was told the resident had an unwitnessed fall out of her wheelchair and was found on the floor. She had a bump on her head and a scant amount of bleeding . The DON stated she wasn't sure if it was reported. She stated the AD would be the one responsible for reporting. During an interview on [DATE] at 4:57 pm, the AD stated the Falling Star Program is something they initiated for HMG facilities to help prevent falls. He said it could include interventions like yellow stars by a resident's name, fall mats, low beds and other interventions as needed. He stated it was internal and not a documented program or procedure. During an interview on [DATE] at 5:12 pm, the AD stated they did not have a policy on Abuse, Neglect, and Exploitation but followed the state provider letter. He stated he was aware of the fall incident on [DATE] with Resident #1 and that she had fallen while seated up at the nurse's station in her wheelchair. He stated he had been notified of the fall that evening but did not get the full picture. He stated, all I was told is she fell , got hurt and we are sending her out. He stated he did not find out about Resident #1 becoming lethargic or them doing CPR until the next morning, [DATE]. He said he called the governing bodies about the incident (his boss) and they said let's wait for the hospital report. That's what was directed to me. He stated later on Monday, [DATE], he got the hospital report, and he gave it to the governing bodies, and they decided it was not a reportable incident because she might have had a heart attack that led to cardiac arrest. We all collaborated and that was the decision they made. I said what I had to say, gave my opinion. He further stated that the incident was not reported but it was investigated. He stated he was the one that completed the investigation, and he would have been the one responsible for reporting it to the state agency . Review of Provider Letter ,d+[DATE] reflected 2.1, A NF must report to HHSC the following types of incidents, in accordance with applicable state and federal requirements: Abuse, Neglect .Death due to unusual circumstances. Further review reflected incidents of suspected abuse or neglect with serious bodily injury should be reported immediately but not later than 2 hours, and incidents that do not result in serious bodily injury but involves a death under unusual circumstances should be reported immediately, but not later than 24 hours after the incident occurs.

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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 - Actual harm 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** 44700 Based on interviews and record review the facility failed to provide adequate supervision and to prevent accidents for one resident (Resident #1) of four reviewed for accidents and hazards. The facility failed to supervise Resident #1 when she was sitting at the nurse's station, which resulted in a fall with injuries on [DATE]. This failure placed residents at risk of accidents or falls resulting in injuries, pain, and hospitalization . Findings included: Review of Resident #1's face sheet dated [DATE] reflected a [AGE] year-old female admitted on [DATE] with diagnoses that included Chronic Kidney Disease, Dementia, Anemia (low iron in blood), Hyperlipidemia (high cholesterol), Glaucoma (eye disorder that clouds vision) and muscle weakness. Review of Resident #1's admission MDS dated [DATE] reflected a BIMS of zero (0) suggesting severe cognitive impairment. Review of MDS section Functional Abilities and Goals reflected resident used a wheelchair for a mobility device. Further review of this MDS section reflected resident needed substantial/maximum assistance for wheelchair mobility to wheel 50 feet with two turns. Review of Resident #1's undated care plan reflected the problem [Resident #1] is high risk for falls r/t DX Dementia with interventions be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance. Ensure a safe environment, floors even and free from spills or clutter, adequate light, bed in low position, personal items within reach, Maintain a clear pathway, free of obstacles. Further review of care plan reflected another problem [Resident #1] has had an actual fall r/t Cognitive impairment [DATE] fall w/o injury, [DATE] fall w/o injury, [DATE], fall w/injury with interventions Falling star program, place fall mat at bedside, PT/OT consult for strength and mobility as needed, [DATE]: sent to ER for further eval. Review of Resident #1's fall assessment dated [DATE], reflected a score of 19 indicating Resident #1 was High Risk for falls. Review of Resident #1's progress notes dated [DATE] at 9:41 pm, but effective [DATE] at 7:45 pm by LVN A, reflected SN down hall passing medication and was called by kitchen staff that patient was in floor near nursing station. When SN arrived at nursing station patient was noted to be on floor near wheelchair. SN and other nursing staff removed patient from floor after assessment completed and patient noted to have a hematoma to the right forehead with scant blood at site. Patient transferred to room via wheelchair. While in room adjusting patient in bed patient noted to have closed eyes and when called by name, patient was unresponsive and showing no sign of life. 911 called and SN with assist of other nursing staff started CPR. Paramedics arrived and took over CPR administration. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:55 pm, FM stated they received a call from the AD at the facility on [DATE] and were told Resident #1 had been left unattended at the nurse's station and fell out of her wheelchair. He stated he was told the nurse got called away to another room and someone in dietary found her on the floor. They had no idea how long she was on the floor. He stated he had been up there that day at lunch time from about 12:15pm to almost 2PM and he fed Resident #1, and she acted very normal to him. He stated, she was doing well, had no heart issues, nothing, but did have a history of falls. During an interview on [DATE] at 1:43 pm, the ADON stated she was not working the night Resident #1 fell , but she reviewed the incident report the next day, [DATE]. She stated she was aware Resident #1 was often at the nurses station because she was a fall risk, but she was not set up to be 1:1, not required to be 1:1. When asked what she would have done in a similar circumstance she stated she would have made sure the wheelchair was locked and the resident was properly positioned in her wheelchair. She stated, I would walk away, but it would depend on how long I would be gone. If I was just going to help an aide change a brief, then it would be okay to walk away . but if I was doing a med pass that would be different because I would be gone for longer period of time .every situation is different . During an interview on [DATE] at 2:14 pm, LVN A stated she was the nurse on the 300 hall on the evening of [DATE]. She stated she had been sitting at the nurses station and Resident #1 was sitting in her wheelchair up at the nurses station. She stated she had gotten up to go down the hall and pass meds and a few minutes later a staff member was calling out for help. She went down to the nurse's station and Resident #1 was lying on her side on the floor and she was bleeding from her head. She stated it was a moderate amount of blood and there was a bump on her head. She stated Resident #1 was conscious and her eyes were open at that time. She assessed her for injuries and then her and other staff put her back in her wheelchair and took her to her room. When they got to Resident #1's room, they moved her from her wheelchair to the bed. At that point, the resident became lethargic and stopped responding. She stated one of the staff called 911 and she went and got the crash cart and then started CPR. LVN A revealed she had received training on falls and fall prevention and knew Resident #1 was a fall risk. When asked why she had left Resident #1 alone at the nurses station she stated, there were other people there and thought they would keep an eye on her. She stated she had not told anyone she was going down the hall to have a conversation with anyone or to keep an eye on Resident t#1. She admitted that the charge nurse was responsible for the residents. She further stated that if a resident was a fall risk and was left unattended they could fall, they could get hurt, go to the hospital. They can get hurt really bad. She stated she felt the fall could have been prevented if Resident #1 had been on 1:1 monitoring . During an interview on [DATE] at 2:46 pm, DA -B stated he had been working on the evening of [DATE] and had been making rounds passing out resident snacks. He stated when he got to the 300 hall nurse's station, about 7:45 pm, he saw a resident lying on the floor on her side, not moving. He stated he called down the hall for help and LVN A came out of one of the rooms. He stated LVN A immediately went to the resident and checked her out and then asked him to go get the nurse on the 100 hall, so he did. He further stated that he could not see if the resident was injured or bleeding because her back was to him when he saw her. He stated he clocked out shortly after that and did not see what else happened. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 3:35 pm, CNA C stated she had been working at the facility a month and often worked the hall that Resident #1 was on and was familiar with the resident. She stated Resident #1 was always getting up out of bed and her chair - all the time. She stated they had to keep an eye on her because if they didn't she could get up and fall. They kept her bed low and fall mats in place when she was in bed. She stated, it's everyone's responsibility to watch residents but ultimately it's the charge nurse's responsibility. She stated Resident #1 was often in her wheelchair at the nurses station so everyone could keep an eye on her . During an interview on [DATE] at 4:20 pm the DON stated she was familiar with the fall incident with Resident #1 on [DATE]. She stated she was called that night and was told Resident #1 fell and had a bump on her head and a scant amount of bleeding. She stated she had seen Resident #1 at the nurses station often and knew she was a fall risk, and this was done for safety - to keep eyes on her. The DON stated all the staff were responsible for the resident's but ultimately the nurse on the hall was responsible. She stated she felt staff responded well to the incident, but she didn't get a lot of detail until the next day. When the DON was asked how she felt about Resident #1 being left unattended at the nurses' station she stated Doesn't make me happy. We need to keep an eye on them, and we didn't do what we needed to do. She further stated she felt it could have been prevented if they had kept eyes on her. She also stated if residents that are high fall risk are not supervised, they can fall, get injured and have to go to the hospital . When asked what she might have done in the same situation she replied, I would have taken her down the hall with me . During an interview on [DATE] at 5:12 pm, the AD stated he was aware of the fall incident on [DATE] with Resident #1 and that she had fallen while seated up at the nurse's station in her wheelchair. He stated he had been notified of the fall that evening but did not get the full picture. He stated, all I was told is she fell , got hurt and we are sending her out. He stated he did not find out about Resident #1 becoming lethargic or them doing CPR until the next morning, [DATE]. He stated the staff knew she was a high fall risk and they had put interventions in place when she did fall. He stated Resident #1 was not on 1:1 monitoring. He stated he did tell the FM the nurse was initially at the nurse's station and then went to pass meds and got called in a room. When asked how the incident was handled by staff after the fall, he stated I think they did a good job. When asked if there was something the staff could have done to prevent the fall, he stated no. The AD stated we all are responsible for the residents. He stated CNAs provide direct care and they would to tell the charge nurse if something was going on with a resident and the charge nurse was ultimately responsible for the residents. He stated his expectation of staff supervision with high fall risk residents was making sure all interventions are in place - reporting in the morning meeting so they can be identified; we have the fall prevention program, use low beds, mats, and call lights . Review of facility policy Safety and Supervision of Residents dated [DATE] reflected Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Further, Individualized, Resident-Centered Approach to Safety, 1. Our individualized, resident center centered approach to safety addresses safety and accident hazards for individual residents .3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.