STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675471	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Star Ranch Rehabilitation and Health Care Ce	709 W Fifth St Bonham, TX 75418

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** 44637 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but , but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury for 1 of 6 (Resident #1) residents reviewed for abuse and neglect. The facility staff did not report to the state agency Resident #1's fractured orbital floor (a break to the thin, bony plate that forms the bottom of the eye socket) and cervical spine fractures, following a fall out of bed during care, that were discovered during a hospital admission starting 1/30/25. This failure could place residents at risk of injuries, abuse, and/or neglect. Findings Include: 1. Record review of the face sheet dated 2/26/25 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including heart failure, hypertension (elevated blood pressure), diabetes, anxiety, and COPD. Record review of the Admission MDS dated [DATE] indicated Resident #1 admitted to the facility from a short-term general hospital on 1/30/25. Record review of the Discharge MDS dated [DATE] indicated Resident #1 discharged from the facility with return anticipated to a short-term general hospital on 1/30/25. Record review of Resident #1's medical records indicated Resident #1 did not have a care plan or physician orders at the time of her discharge from the facility. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the hospital records for Resident #1's admission starting 1/30/25 indicated, [Resident #1] arrived by EMS due to fall/AMS from [nursing facility], [Resident #1] just arrived to the facility from the hospital for unknown reasons. staff was working on patients wound vacs, the bed was not locked, and patient fell out onto face, swelling, bruising to [left] eye, [laceration] to [left] side of forehead. The hospital records indicated Resident #1 had a notable orbital fracture and nondisplaced fractures (a type of fracture where the bone fragments remain in their original position without shifting) on C-spine (cervical spine) osteophytes (a bony growth that develops on the edge of a bone). The hospital records discharge summary indicated Resident #1 was status post fall from the bed with an orbital wall fracture with possible muscle entrapment and equivocal (a situation where the muscle gets trapped within a fractured bone or other tissue, often causing limitation in movement, while equivocal means uncertain or ambiguous), tiny acute or subacute fractures (stress fracture) of the anterior (nearer to the front) osteophytes along the inferior endplate of C6 bilaterally (a flat, bilayer cartilage that helps stabilize the vertebral column). During an interview on 2/20/25 at 10:03 a.m. the MDS Coordinator/ADON said Resident #1 was only in the facility for approximately an hour before she was sent to the ER, and they did not have time to complete a baseline care plan or any of her other medical records or assessments in their computer system. During an interview on 2/26/25 at 9:06 a.m. the Marketer said she had been at the facility since November 2024. The Marketer said Resident #1 had not been in the facility but maybe a couple hours when she was sent out to the hospital. The Marketer said she contacted the Case Manager in the morning (no date given) and was told Resident #1 had a CT that was negative, her left eye was swollen shut, and she had 8-10 sutures above her left eye. The Marketer said later (time not specified) the Case Manager informed her Resident #1 had several small fractures of the C-Spine (cervical spine) and of her left orbital floor. The Marketer said she did not report that information to the Administrator as the facility did not have an administrator at that time. The Marketer said the MDS Coordinator/ADON had been keeping in touch with the Resident #1's as well. During an interview on 2/26/25 at 9:35 a.m. the MDS Coordinator/ADON said she had spoken with Resident #1's family member on 1/30/25 regarding the fall on 1/30/25. The MDS coordinator/ADON said the family member came by the facility and said he understood things happened. The MDS Coordinator/ADON said the family member never gave her any information regarding Resident #1's diagnosis at the hospital. The MDS Coordinator/ADON said that was the last time she had any communication with Resident #1's family. During an interview on 2/27/25 at 10:30 a.m. the MDS Coordinator/ADON said on 1/30/25 the Regional Nurse would have been responsible for calling incidents into the state agency. The MDS Coordinator/ADON said she reported the incident of Resident #1 having a fall while care was providing care to the Regional Nurse on 1/30/25, but due to the fact they knew what happened and how the injuries occurred they did not think it was a reportable incident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/27/25 at 10:43 a.m. the Regional Nurse said the MDS Coordinator/ADON had made her aware of the incident on 1/30/25 regarding Resident #1 falling. The Regional Nurse said they had a conference call (date not given) regarding the incident, and she asked if the bed was locked. The Regional Nurse said she had been informed Resident #1's bed was locked at the time of her fall. The Regional Nurse said it was determined the incident was not reportable to the state agency due to it being a witnessed fall and knowing how the injury occurred. The Regional Nurse said the facility did not receive any hospital updates to know the extent of Resident #1's injuries. The Regional Nurse said she was not aware the Marketer had been updated by the Hospital Case Manager regarding Resident #1's injuries. The Regional Nurse said she found out about Resident #1's injuries on 2/26/25 when the surveyor notified the facility. Record review of the facility's Abuse Prohibition policy last revised 5/17/24 indicated, This protocol was intended to assist in the prevention of abuse, neglect, and misappropriation of property. Each resident has the right to be free from abuse, mistreatment, neglect, corporal punishment, involuntary seclusion, and financial abuse .The Abuse Coordinator will report such allegation to the state agency in accordance with state law. The Abuse Coordinator will report all allegations of abuse, neglect with serious bodily injury, mistreatment with serious bodily injury, exploitation with serious bodily injury, and injuries of unknown source with serious bodily injury within two hours of the allegation. The Abuse Coordinator will report all other allegation of neglect, mistreatment, exploitation, injuries of unknown source and misappropriation within 24 hours of the allegation .

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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** 44637 Based on observation, interview, and record review the facility failed to ensure that the resident environment remained free of accident hazards and each resident was provided adequate supervision to prevent injuries for 1 of 6 residents (Resident #1) reviewed for accident hazards. The facility failed to ensure Resident #1's bed was locked while providing care resulting in a fall with fractures to the orbital floor (a break to the thin, bony plate that forms the bottom of the eye socket) and cervical spine on 1/30/25. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 2/26/25 at 12:00 p.m. While the IJ was removed on 2/27/25, the facility remained out of compliance at no actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk for serious harm, impairment, or death. Findings include: 1. Record review of the face sheet dated 2/26/25 indicated Resident #1 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses including heart failure, hypertension (elevated blood pressure), diabetes, anxiety, and COPD. Record review of the Admission MDS dated [DATE] indicated Resident #1 admitted to the facility from a short-term general hospital on 1/30/25. Record review of the Discharge MDS dated [DATE] indicated Resident #1 discharged from the facility with return anticipated to a short-term general hospital on 1/30/25. Record review of Resident #1's medical records indicated Resident #1 did not have a care plan or physician orders at the time of her discharge from the facility. Record review of the progress note dated 1/30/25 written by RN A indicated, [Resident #1] admitted facility, while doing assessment and applying wound Vac. [CNA B was] on left side of bed, bed did not lock as was thought, bed moved causing resident to fall to floor bed in semi high position. [CNA B] was unable to keep [Resident #1] from falling to floor. [Resident #1] hit her head causing a laceration to top of left forehead and also hit her left eye causing a hematoma (a localized collection of blood outside of the blood vessel) to eye. Due to nature of fall [Resident #1] was sent to local ER for sutures and evaluation. [Family] and MD made aware of incident. Record review of the incident report dated 1/30/25 written by RN A indicated, While doing assessment on [Resident #1] and wound measurements and to apply wound vac [CNA B] on other side [of bed] to hold [Resident #1], bed moved causing [CNA B] to lose her hold on [Resident #1]. The incident report indicated immediate action taken by the facility was Resident #1 was sent out to the ER. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the hospital records for Resident #1's admission starting 1/30/25 indicated, [Resident #1] arrived by EMS due to fall/AMS from [nursing facility], [Resident #1] just arrived to the facility from the hospital for unknown reasons. staff was working on patients wound vacs, the bed was not locked, and patient fell out onto face, swelling, bruising to [left] eye, [laceration] to [left] side of forehead. The hospital records indicated Resident #1 had a notable orbital fracture and nondisplaced fractures (a type of fracture where the bone fragments remain in their original position without shifting) on C-spine (cervical spine) osteophytes (a bony growth that develops on the edge of a bone). The hospital records discharge summary indicated Resident #1 was status post fall from the bed with an orbital wall fracture with possible muscle entrapment and equivocal (a situation where the muscle gets trapped within a fractured bone or other tissue, often causing limitation in movement, while equivocal means uncertain or ambiguous), tiny acute or subacute fractures (stress fracture) of the anterior (nearer to the front) osteophytes along the inferior endplate of C6 bilaterally (a flat, bilayer cartilage that helps stabilize the vertebral column). During an interview on 2/20/25 at 10:03 a.m. the MDS Coordinator/ADON said Resident #1 was only in the facility for approximately an hour before she was sent to the ER, and they did not have time to complete a baseline care plan or any of her stuff in their computer system. During an interview on 2/26/25 at 9:38 a.m. RN A said Resident #1 entered the facility at the end of her shift on 1/30/25. RN A said she went to Resident #1's room to perform a skin assessment and apply the wound vac to the wound on her bottom. RN A said she had her head down when CNA B said, Oh no. RN A said Resident #1 fell to the floor. RN A said she thought she locked the bed but could not say for sure if it was locked. During an interview on 2/26/25 at 9:46 a.m. CNA B said on 1/30/25 she was assisting RN A with wound care on Resident #1. CNA B said Resident #1 was rolled up on her side. CNA B said she and RN A had thought the bed was locked but it was not, and the bed moved. CNA B said she attempted to hold Resident #1 up from falling but was unable to. CNA B said Resident #1 fell to the floor. Record review of the facility's Fall Prevention Program policy revised 6/10/24 indicate, All resident will be assessed for the risk for falls at the time of admission, on a quarterly basis, and upon significant change in condition thereafter. Based on the results of this assessment, specific interventions will be implemented to minimize falls, avoid repeat falls, and minimize falls resulting in significant injury . The Administrator was notified on 2/26/25 at 12:06 p.m. that an Immediate Jeopardy situation was identified due to the above failure. The Administrator was provided the Immediate Jeopardy template on 2/26/25 at 12:11 p.m. The facility's Plan of Removal was accepted on 2/26/25 at 6:30 p.m. and included: Immediately on 2/26/25, Regional Nurse in-serviced Administrator and ADON regarding Accident Hazards/Supervision/Devices, making sure all beds are properly locked prior to providing care to resident. If not working, ensure resident safety, remove equipment from use and notify maintenance director immediately. Competency verified via quiz. Licensed nurse was in-serviced by ADON on 2/26/25 with competency validation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/26/25, the ADON/Designee initiated in-services with all facility staff regarding Accident Hazards/Supervision/Devices, making sure all beds are properly locked prior to providing care to resident. If not working, ensure resident safety, remove equipment from use and notify maintenance director immediately. Competency was verified via quiz. Staff will not be allowed to work until in-servicing has been completed on 2/26/25. The above content was incorporated into new hire orientation by Administrator effective 2/26/25. On 2/26/25, the Maintenance Director checked all beds and mobility devices to ensure safe working order. Any concerns were immediately repaired or replaced. The Medical Director was notified on 2/26/25. In order to monitor compliance, the Maintenance Director will check beds and mobility equipment weekly x4 weeks and monthly thereafter x 3 months. The ADON/designee will do periodic checks during resident care to ensure compliance daily x4 weeks than monthly thereafter x 3 months. Any negative findings will be corrected and reported to the QAPI committee to ensure continued compliance. The facility will meet weekly for the next eight weeks to review compliance with the plan of action. No further concerns are noted, will continue to monitor as per routine facility QA Committee. On 2/27/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the monitoring sheets indicated on 2/26/25 all beds and wheelchairs in the facility were checked to ensure they locked and working properly. Observations on 2/27/25 of randomly selected beds in the facility indicated 10 out of 10 beds checked locked properly and did not move when locked. Record review of in-services dated 2/26/25 indicated the Administrator, MDS Coordinator/ADON, and facility staff had been in-serviced regarding accidents hazards/supervision/devices, making sure all equipment (beds and wheelchairs) were in proper working order and the locks were working, and if equipment locks were not working properly notify maintenance. Record review of competency quizzes dated 2/26/25 indicated all staff interviewed by the surveyor as listed below had completed the competency quiz with questions including do you check to confirm bed is locked each time before providing care; if you are providing care for a resident and lock the bed, how do you confirm it is locked; what do you do if you test the bed and the lock is not working; and if you noticed equipment is not working, you should immediately ensure resident safety, remove equipment form you, and report to the Administrator/Maintenance Director with 100% accuracy. During an interview on 2/27/25 at 9:20 a.m. the Adminsitrator said he had been in-serviced by the Regional Nurse regarding ensuring locks on beds and wheelchairs were routinely checked and in working order, ensuring beds were locked prior to staff providing care for a resident, and staff's responsibility for reporting to management and the Maintenance Director of locks not working properly on beds or whellchairs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviewed (MA C, CNA B, CNA D, CNA E, LVN F, RN G, LVN H, CNA J, CNA K, Housekeeper L, CNA M, the AD, LVN N, and the MDS Coordinator/ADON) who worked across all shifts on 2/27/25 between 9:23 a.m. and 10:22 a.m. were able to verbalize when locks should be checked on beds and wheelchairs, the importance of ensuring locks were properly locked and working prior to providing care for a resident, and what to do if a lock was not working properly. During an interview on 2/27/25 at 10:24 a.m. the Maintenance Director said he had checked to ensure all beds in the facility had proper working locks and logged the results. The Maintenance Director said he would be checking the locks weekly for a few weeks and then monthly thereafter. On 2/27/25 at 10:29 a.m., the Administrator was informed the IJ was removed; however, the facility remained out of compliance at no actual harm with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.