STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675484	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Park Nursing & Rehab	101 Woodland Park Dr Shepherd, TX 77371

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to coordinate assessments with the PASRR program, including incorporating the recommendations from the PASRR evaluation report into a resident's care planning for 1 of 2 residents reviewed for PASRR assessments. (Resident #2) The facility did not provide and arrange for a specialized customized manual wheelchair for Resident #2 as recommended and agreed upon by the IDT within the time frame set by PASRR. This failure could place residents who are PASRR positive at risk of not receiving the necessary services/DME that would enhance their quality of life. Findings included: Record review of a face sheet dated 04/23/25 indicated Resident #2 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture due to abnormal brain development), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), chronic osteomyelitis of the left tibia and fibula (bone infection of the 2 bones of the lower leg), and lymphedema (a condition characterized by swelling caused by an accumulation of protein-rich fluid in the body's tissues primarily affecting the arms or legs). Record review of the current MDS dated [DATE] indicated Resident #2 had severely impaired cognition, required substantial/maximal assistance for all ADLs, and used a manual wheelchair. Record review of an undated IDT and NFSS Complaint Report indicated Resident #2 had an initial IDT meeting on 10/18/24; services recommended and agreed on were OT Assessment, PT Assessment, ST Assessment, CMWC Service, and OT Service. The report also indicated an email was sent to the Administrator and MDS Nurse on 01/08/25 and a follow-up phone call was conducted on 01/27/25. Record review of a PCSP dated 01/27/25 for Resident #2 indicated Medicaid Eligibility was marked as 1. ME Confirmed; the IDT recommended and agreed on a CMWC, Specialized Assessment OT, Specialized Assessment PT, Specialized Assessment ST, Specialized OT, Specialized PT, Habilitation Coordination, and Independent Living Skills Training. (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
	675484	A. Building B. Wing	04/24/2025

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of an email dated 01/29/25 from the Administrator to the MDS Nurse regarding the NFSS PASRR Compliance Request indicated he was contacted by the PASRR Unit-Program Specialist by phone. He indicated in the email the NFSS needed to be completed in the portal as soon as possible. Record review of a care plan last revised 01/16/2025 indicated Resident #2 was PASRR positive (screening to identify if resident has PASRR conditions serious mental illness, intellectual disability, developmental disability or related conditions) for ID/DD: schizoaffective disorder-depressive type and cerebral palsy. Goals included for Resident #4 will receive specialized services to meet her needs related to ID/DD/MI to promote her highest level of function through the review period. Interventions included complete and submit new PL1 from the MDS for any re-admission or change of condition for the PE positive status for any new services she requires; agreed to receive the following services: Habilitation PT/OT/ST, Habilitation Coordination, and Independent Living Skills Training; notify local authority of routine IDT meeting, change of condition, and any specialized services needed; notify therapy dept. of PE positive status to ensure they are screening quarterly and prn for any specialized services she may require; and schedule IDT meeting with local authority, Physician, family, and any other entities involved with her care within 14 days of an admission. During an observation and interview on 04/21/25 at 11:30 a.m., Resident #2 was sitting in her standard wheelchair in her room. She was not able to answer surveyor's questions. During an interview on 04/23/25 at 09:02 a.m., the MDS Nurse said a meeting was done on 10/18/24 for Resident #4. She said the IDT recommended and agreed on a CMWC, Specialized Assessment OT, Specialized Assessment PT, Specialized Assessment ST, Specialized OT, Specialized PT, Habilitation Coordination, and Independent Living Skills Training. She said Resident #4 was in and out of the hospital and returned on Medicare A several times, so they were not able to submit the NFSS because she had changed payor source to Medicare A. She said she was aware of the required time frames for submitting information since she was the corporate MDS Nurse prior to taking the position of the facility MDS Nurse. During an interview on 04/23/25 at 09:50 a.m. the BOM said Resident #2's payor source was Medicare A for November and December 2024 because she had been in and out of the hospital frequently. She said Resident #2's payor source was Medicaid on 01/10/25 and remained until 03/13/25 when she returned to the hospital. During an interview on 04/24/25 at 01:27 p.m., the MDS Nurse said another meeting was done on 01/27/25 for Resident #2. She said the IDT recommended and agreed on a CMWC, Specialized Assessment OT, Specialized Assessment PT, Specialized Assessment ST, Specialized OT, Specialized PT, Habilitation Coordination, and Independent Living Skills Training again. She said the physician/Medical Director did not sign the PASRR NFSS form to be submitted and went out of the country. She said they had since changed the Medical Director and were in the process of getting the NFSS signed and submitted. During an interview on 04/23/25 at 11:30 a.m., DON H said the MDS Nurse was responsible for coordinating all things PASRR related. She said she was not employed at the facility at the time Resident #2 had the IDT meetings. She said as far as she knew the corporate MDS Nurse monitored the facility MDS Nurse. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 3:20 p.m., the Administrator acknowledged he sent an email on 01/29/25 to the MDS Nurse indicating the PASRR Unit Program Specialist had called about the NFSS form not submitted and it needed to be submitted immediately. He said the MDS Nurse was responsible for the PASRR. Record review of a facility policy titled Policy and Procedure for PL1/PASRR/NFSS/1012/PCSP revised 01/16/19 indicated . Rationale: The facility will ensure compliance with all Phase I and II guidelines of the PASRR process for Long Term Care 11. Notify physicians and obtain orders for recommended items, write orders in PCC, notify Therapy of new orders, and submit NFSS forms for specific recommendations. Remember the recommendations must be completed within 25 days of the submission of the IDT form.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 30664 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 10 residents (Resident #1, Resident #2, and Resident #3) reviewed for care plans. * The facility failed to develop a person-centered care plan with interventions that addressed Resident #1's Fall Risk Assessment which indicated he was a high risk for falls. Resident #1 had a fall and was sent to the emergency room for assessment. A CT scan of the neck determined he had a fracture of one of the cervical vertebrae. * The facility failed to update Resident #2's care plan after she had 2 falls. * The facility failed to develop a person-centered care plan with interventions that addressed Resident #3's Fall Risk Assessment which indicated she was a high risk for falls after she had a fall. An Immediate Jeopardy (IJ) was identified on 04/23/25 at 04:44 p.m. and the IJ template was provided to the Administrator. While the immediacy was removed on 04/24/25 at 02:50 p.m., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents who were assessed as high risk for falls at risk of serious harm and injury. Findings included: 1. Record review of face sheet dated 09/19/2024 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (head injury causing damage to the brain by external force or mechanism) from a MVA [AGE] years ago; paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body); arterial ulcers (skin injuries caused by inadequate blood supply to the affected area) to heel, ankle, and toe; intracranial injury (any injury occurring within the skull) with loss of consciousness; lack of coordination; osteoarthritis (inflammation of one or more joints); and abnormalities of gait and mobility. Record review of Fall Risk Assessments dated 07/06/24 and 08/04/24 indicated Resident #1 was a high risk for falls. Record review of Resident #1's comprehensive care plans initiated on 07/08/24 did not address Resident #1's Fall Risk Assessment of high risk with interventions to implement to prevent falls or injuries from falls. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated a BIMS score of 6 indicating Resident #1 had severely impaired cognition. Resident #1 required substantial/maximal assistance for transfers and all ADLs. He used a manual wheelchair. He had no falls since admission. Record review of Nurse Notes indicated an entry on 08/16/24 at 02:00 p.m. that Resident #1 was placed on a low air loss mattress due to open area to his sacrum. There was no documentation of interventions to prevent potential falls after placement. Record review of Nurse Notes indicated an entry on 08/17/2024 01:40 p.m. that Resident #1 was on his right side on the floor by his bed. He was assisted back to the bed. Resident #1 said he did not know how he fell . He just knew he was on the floor. He had a 5cm x 3cm swollen area right side of head, 3cm x 2cm skin tear on the lateral aspect of the right elbow, and the right side of his face had swelling. Record review of a telehealth noted dated 08/17/24 indicated Resident #1 had unwitnessed fall with a knot to right side of forehead and redness to right side of face. Record review of an incident report dated 08/17/24 indicated Resident #1 was found on the floor. According to the incident report, he was put back in the bed and a head-to-toe assessment was done with a 5cm x 3cm swollen area to the right side of head, a 3cm x 2cm skin tear on the lateral aspect of his right elbow, and the right side of his face had swelling. The NP saw Resident #1 via telehealth and ordered him to be sent to the hospital ER. Record review of the hospital CT scan report of the neck dated 08/17/24 showed Resident #1 had a question age-indeterminate non-displaced type 3 (extend into the body of the vertebra) odontoid (a bony element extending superiorly from the second cervical vertebra) fracture (break). He returned to the facility with an order to wear a neck brace for 8 weeks. Record review of a Bed Rail/Assist Bar Evaluation dated 08/18/24 indicated Resident #1 had assessment done for post fall. A. Evaluation Factors 1. Resident has expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort. 1A. If selected, explain: Resident will use for turning and repositioning 6. Resident has a history of falls. 7. The resident is having problems with balance or poor trunk control. 7A. If yes, explain: Resident is on low air loss mattress and needs the rails for support C. Summary of Findings 1. Summary of findings: Resident will use rails as assist bar and bed bolsters used to help prevent legs from slipping over edge of the air mattress. Resident uses call light for assistance and historically has not tried to get up alone. Resident #1 had been discharged to the hospital on 09/16/24, did not return to the facility, and was not available for interview. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/22/25 at 03:15 p.m. DON J said she was working at the facility when Resident #1 had his fall that ended with the fractured neck. She said she remembered he could be non-compliant at times. She said the resident had no issues with any falls prior to the fall but if he was a high risk according to the assessment then interventions should have been in place. She said she did not remember if there were fall mats placed. She said she did remember the bed had partial rails on it prior to them having to put an air mattress on the bed due to an open wound. She said the air mattress obtained was too big, so they had to take the rails off. She said they had obtained one to fit the bed, but she guessed the rails were not put back on the bed and he fell the next day. She said the air mattress could be an increased risk for falls since they are slick, and you can't put sheets on them. 2. Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture due to abnormal brain development), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), chronic osteomyelitis of the left tibia and fibula (bone infection of the 2 bones of the lower leg), and lymphedema (a condition characterized by swelling caused by an accumulation of protein-rich fluid in the body's tissues primarily affecting the arms or legs). Record review of the current MDS dated [DATE] indicated Resident #2 had severely impaired cognition, required substantial/maximal assistance for all ADLs, and had no falls since last assessment. Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 was not a high risk for falls. Record of the Incident Log from 07/21/24 through 12/07/24 indicated Resident #2 had an unwitnessed fall on 12/07/24. Record review of a care plan initiated on 12/07/24 indicated Resident #2 was a high risk for falls. She had a fall with no injury on 12/07/24. The only intervention was sent to ER for eval and treat of unrelieved pain. No other interventions to prevent falls or potential injuries from falls were developed. Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 was a high risk for falls. Record of the Incident Log from 07/21/24 through 02/11/25 indicated Resident #2 had an unwitnessed fall on 02/11/25. i Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 had a fall and was a high risk for falls. Record review of a care plan revised on 02/22/25 indicated on 02/11/25 Resident #2 had a fall with no injury and intervention was FNP review of medications, lab work, psych notified, notified PASRR LA for behavioral assessment. No other interventions to prevent falls or potential injuries from falls were developed. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an observation and interview on 04/23/25 at 11:25 a.m., Resident #2 was in her room in a wheelchair. Her bed had 1/4 side rails. She was not able to answer questions. 3. Record review of a face sheet dated 04/23/25 indicated Resident #3 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included end stage renal disease (last stage of long-term kidney disease), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), type 2 diabetes mellitus (A chronic condition that affects the way the body processes blood sugar), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), hypertension (condition in which the force of the blood against the artery walls is too high), atrial fibrillation (a type of irregular heartbeat), cardiac arrhythmia (occurs when the electrical signals that tell the heart to beat do not work properly), and heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs). Record review of the current MDS dated [DATE] indicated Resident #3 was cognitively intact, required partial/moderate assistance for bed mobility, was dependent with transfers, required substantial/maximal assistance with most ADLs, used a manual wheelchair, and had no falls since prior assessment. Record review of a Fall Risk assessment dated [DATE] indicated Resident #3 was not a high risk for falls. Record review of an incident report dated 01/22/25 indicated Resident #3 said she was sitting in her wheelchair getting a breathing treatment. She saw a bug crawling up the wall. She rolled to the wall, leaned forward. She forgot to lock the wheels. The wheelchair rolled out from under her. She landed flat on her bottom. Her back and tail bone hurts, 9/10 rating. Record review of an x-ray result for Resident #3 dated 01/22/25 indicated 1) x-ray of lumbar spine impression: No acute fracture or dislocation of the lumbar spine. 2) x-ray of sacrum/coccyx impression: No acute fracture or dislocation of the sacrum/coccyx. Record review of Resident #3's Fall Risk assessment dated [DATE] indicated the assessment was done due to a fall and she was at high risk for falls. Record review of Resident #3's care plan dated 01/24/25 indicated revisions to the care plan on 01/30/25 for 1/4 rails on the bed for safety/enabler. There was no care plan for the fall she had on 01/22/25. During an observation and interview on 04/23/25 at 09:20 a.m., Resident #3 was in her bed. She said she had a fall a few months ago. She said the rails on her bed to help her with being able to turn in the bed. During an interview on 04/23/25 at 12:40 p.m., DON H said the MDS Nurse, the CN, the ADON, or herself were responsible for completing comprehensive care plans and updating the care plan as needed. DON H said her expectation would be for all residents at risk for falls or had a fall to have care plan initiated and updated with additional interventions. She said an air mattress would not increase a resident's risk for falls. She said interventions would be based on the resident's needs. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/23/25 at 01:30 p.m., the Administrator said nursing was responsible to complete all the care plans and updating them for the residents. Record review of a Falls and Fall Risk Managing policy revised March 2018 indicated: 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. Policy Interpretation and Implementation Fall Risk Factors: 2. Resident conditions that may contribute to the risk of falls include: a. fever; b. infection; c. delirium and other cognitive impairment; pain; d. lower extremity weakness; e. poor grip strength; f. medication side effects; g. orthostatic hypotension; h. functional impairments; i. visual deficits; and j. incontinence. 3. Medical factors that contribute to the risk of falls include: a. arthritis; b. heart failure; c. anemia; d. neurological disorders; and balance and gait disorders; etc. Resident-Centered Approaches to Managing Falls and Fall Risk (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling The Administrator and DON H were notified of the Immediate Jeopardy on 04/23/25 at 04:44 p.m. and was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The following Plan of Removal was submitted by the facility and accepted on 04/23/25 at 8:30 p.m. F656- All items listed will be completed by 5:00 PM on 4/24/25 with continued follow-up for scheduled staff. 1. Administrator/DON initiated an in-service regarding policy and procedure for initiation of care plans for falls for licensed staff on 4/23/25. 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. The corporate MDS Nurse and the facility MDS Nurse initiated a review of all care plans for current accident/interventions in place to ensure it's on the care plan and a viable intervention. This action started on 4/23/25. 3. Administrator/DON initiated an update on all fall risk assessments that they are accurate, interventions are in place and care plan coincides. 4. The Administrator and DON all licensed nursing staff on fall policy procedure and interventions post fall. This action started on 4/23/25. 5. MDS Nurse and DON will ensure new admissions have appropriate care plans placed for risk assessments. All licensed nursing staff will in-serviced on implementing interventions for new admissions. This action started on 4/23/2025. 6. Administrator and DON were in-serviced on 4/24/2025 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. 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. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Medical Director was made aware of the Immediate Jeopardy 04/23/25 at 5:15 p.m. 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 04/23/25 with attendance of Administrator, Director of Nursing, MDS Coordinator, Regional Director of Clinical Services, and Chief Operating Officer. This plan was initially implemented 04/23/25 and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is 04/24/25 by 5:00 p.m. with continuation of oncoming staff and follow-up. Monitoring: Record review and interviews of completed: * Record review of the In-Services indicated the Administrator and DON H were in-serviced on 4/24/2025 by Regional Director of Clinical Services on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, and to notify regional/corporate staff of ALL falls/incidents care plans and are to notify regional/corporate staff of any discrepancies. * Record review of a resident list indicated the Corporate Nurse, DON H, and the MDS Nurse reviewed all care plans for current accident/interventions in place to ensure it's on the care plan and a viable intervention. Completed on 04/24/25. * Record review of a resident list indicated the Corporate Nurse, DON H, and the MDS Nurse initiated an update on all fall risk assessments that they are accurate, interventions are in place and care plan coincides. Completed on 04/24/25. * Record review of an In-Service signature sheet indicated the Administrator/DON H initiated an in-service regarding policy and procedure for initiation of care plans for falls for licensed staff on 4/23/25. 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. On 04/24/25 at 01:20 p.m. 13 licensed staff employed were in-serviced. One licensed staff on FMLA was left to in-service. * Record review of an In-Service signature sheet indicated the Administrator and DON H initiated an in-service for all licensed nursing staff on fall policy procedure and interventions post fall. On 04/24/25 at 01:20 p.m. 13 licensed staff employed were in-serviced. One licensed staff on FMLA was left to in-service. During an interview on 04/24/25 at 08:20 a.m., DON H said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, to notify regional/corporate staff of all falls/incidents care plans, and to notify regional/corporate staff of any discrepancies. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 08:25 a.m., the Administrator said he had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, to notify regional/corporate staff of ALL falls/incidents care plans, and to notify regional/corporate staff of any discrepancies. During an interview on 04/24/25 at 08:35 a.m., the MDS Nurse said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 08:45 a.m., the ADON said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 09:15 a.m., RN A said she worked the 6a to 6p shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 09:25 a.m., LVN B said she worked the 6a to 6p shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 10:03 a.m., LVN C said she worked the 6p to 6a shift. She said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 10:06 a.m., LVN D said she worked PRN. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 12:02 p.m., LVN E said she worked the 6p to 6a shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 12:49 p.m., RN F said she was the weekend RN. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 01:08 p.m., LVN G said she worked the 6p to 6a shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. The Administrator and Regional Director of Operations were informed the Immediate Jeopardy was removed on 04/24/25 at 02:50 p.m. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrected system that were put into place.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** 30664 Based on observation, interview, and record review the facility failed to provide supervision and assistance devices to prevent accident for 3 of 10 residents (Resident #1, Resident #2, and Resident #3) reviewed for accidents/supervision. * The facility failed to ensure Resident #1 had interventions in place that addressed Resident #1's Fall Risk Assessment which indicated he was a high risk for falls. Resident #1 had a fall and was sent to the emergency room for assessment. A CT scan of the neck determined he had a fracture of one of the cervical vertebrae. * The facility failed to ensure Resident #2 had interventions in place after she had 2 falls. * The facility failed to ensure Resident #3 had interventions in place that addressed Resident #3's Fall Risk Assessment which indicated she was a high risk for falls after she had a fall. An Immediate Jeopardy (IJ) was identified on 04/23/25 at 04:44 p.m. and the IJ template was provided to the Administrator. While the immediacy was removed on 04/24/25 at 02:50 p.m., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents who were assessed as high risk for falls at risk of at risk of potential accidents, serious injuries, serious harm, or death. Findings included: 1. Record review of face sheet dated 09/19/2024 indicated Resident #1 was a [AGE] year-old male admitted on [DATE]. His diagnoses included traumatic brain injury (head injury causing damage to the brain by external force or mechanism) from a MVA [AGE] years ago; paraplegia (injury to the spinal cord or brain that stops signals from reaching the lower body); arterial ulcers (skin injuries caused by inadequate blood supply to the affected area) to heel, ankle, and toe; intracranial injury (any injury occurring within the skull) with loss of consciousness; lack of coordination; osteoarthritis (inflammation of one or more joints); and abnormalities of gait and mobility. Record review of Fall Risk Assessments dated 07/06/24 and 08/04/24 indicated Resident #1 was a high risk for falls. Record review of Resident #1's comprehensive care plans initiated on 07/08/24 did not address Resident #1's Fall Risk Assessment of high risk with interventions to implement to prevent falls or injuries from falls. Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated a BIMS score of 6 indicating Resident #1 had severely impaired cognition. Resident #1 required substantial/maximal assistance for transfers and all ADLs. He used a manual wheelchair. He had no falls since admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Nurse Notes indicated an entry on 08/16/24 at 02:00 p.m. that Resident #1 was placed on a low air loss mattress due to open area to his sacrum. There was no documentation of interventions to prevent potential falls after placement. Record review of Nurse Notes indicated an entry on 08/17/2024 01:40 p.m. that Resident #1 was on his right side on the floor by his bed. He was assisted back to the bed. Resident #1 said he did not know how he fell . He just knew he was on the floor. He had a 5cm x 3cm swollen area right side of head, 3cm x 2cm skin tear on the lateral aspect of the right elbow, and the right side of his face had swelling. Record review of a telehealth noted dated 08/17/24 indicated Resident #1 had unwitnessed fall with a knot to right side of forehead and redness to right side of face. Record review of an incident report dated 08/17/24 indicated Resident #1 was found on the floor. According to the incident report, he was put back in the bed and a head-to-toe assessment was done with a 5cm x 3cm swollen area to the right side of head, a 3cm x 2cm skin tear on the lateral aspect of his right elbow, and the right side of his face had swelling. The NP saw Resident #1 via telehealth and ordered him to be sent to the hospital ER. Record review of the hospital CT scan report of the neck dated 08/17/24 showed Resident #1 had a question age-indeterminate non-displaced type 3 (extend into the body of the vertebra) odontoid (a bony element extending superiorly from the second cervical vertebra) fracture (break). He returned to the facility with an order to wear a neck brace for 8 weeks. Record review of a Bed Rail/Assist Bar Evaluation dated 08/18/24 indicated Resident #1 had assessment done for post fall. A. Evaluation Factors 1. Resident has expressed a desire to have bed rails/assist bar while in bed for their own safety and/or comfort. 1A. If selected, explain: Resident will use for turning and repositioning 6. Resident has a history of falls. 7. The resident is having problems with balance or poor trunk control. 7A. If yes, explain: Resident is on low air loss mattress and needs the rails for support C. Summary of Findings 1. Summary of findings: Resident will use rails as assist bar and bed bolsters used to help prevent legs from slipping over edge of the air mattress. Resident uses call light for assistance and historically has not tried to get up alone. Resident #1 had been discharged to the hospital on 09/16/24, did not return to the facility, and was not available for interview. During an interview on 04/22/25 at 03:15 p.m. DON J said she was working at the facility when Resident #1 had his fall that ended with the fractured neck. She said she remembered he could be non-compliant at times. She said the resident had no issues with any falls prior to the fall but if he was a high risk according to the assessment then interventions should have been in place. She said she did not remember if there were fall mats placed. She said she did remember the bed had partial rails on it prior to them having to put an air mattress on the bed due to an open wound. She said the air mattress obtained was too big, so they had to take the rails off. She said they had obtained one to fit the bed, but she guessed the rails were not put back on the bed and he fell the next day. She said the air mattress could be an increased risk for falls since they are slick, and you can't put sheets on them. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	2. Record review of a face sheet dated 04/23/2025 indicated Resident #2 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included cerebral palsy (congenital disorder of movement, muscle tone, or posture due to abnormal brain development), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), chronic osteomyelitis of the left tibia and fibula (bone infection of the 2 bones of the lower leg), and lymphedema (a condition characterized by swelling caused by an accumulation of protein-rich fluid in the body's tissues primarily affecting the arms or legs). Record review of the current MDS dated [DATE] indicated Resident #2 had severely impaired cognition, required substantial/maximal assistance for all ADLs, and had no falls since last assessment. Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 was not a high risk for falls. Record of the Incident Log from 07/21/24 through 12/07/24 indicated Resident #2 had an unwitnessed fall on 12/07/24. Record review of a care plan initiated on 12/07/24 indicated Resident #2 was a high risk for falls. She had a fall with no injury on 12/07/24. The only intervention was sent to ER for eval and treat of unrelieved pain. No other interventions to prevent falls or potential injuries from falls were developed. Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 was a high risk for falls. Record of the Incident Log from 07/21/24 through 02/11/25 indicated Resident #2 had an unwitnessed fall on 02/11/25. Record review of a Fall Risk assessment dated [DATE] indicated Resident #2 had a fall and was a high risk for falls. Record review of a care plan revised on 02/22/25 indicated on 02/11/25 Resident #2 had a fall with no injury and intervention was FNP review of medications, lab work, psych notified, notified PASRR LA for behavioral assessment. No other interventions to prevent falls or potential injuries from falls were developed. During an observation and interview on 04/23/25 at 11:25 a.m., Resident #2 was in her room in a wheelchair. Her bed had 1/4 side rails. There were no fall mats on the floor by the bed and the bed was not in the lowest position. She was not able to answer questions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	3. Record review of a face sheet dated 04/23/25 indicated Resident #3 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included end stage renal disease (last stage of long-term kidney disease), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), type 2 diabetes mellitus (A chronic condition that affects the way the body processes blood sugar), bipolar disorder (mental disorder associated with episodes of mood swings ranging from depressive lows to manic highs), hypertension (condition in which the force of the blood against the artery walls is too high), atrial fibrillation (a type of irregular heartbeat), cardiac arrhythmia (occurs when the electrical signals that tell the heart to beat do not work properly), and heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs). Record review of the current MDS dated [DATE] indicated Resident #3 was cognitively intact, required partial/moderate assistance for bed mobility, was dependent with transfers, required substantial/maximal assistance with most ADLs, used a manual wheelchair, and had no falls since prior assessment. Record review of a Fall Risk assessment dated [DATE] indicated Resident #3 was not a high risk for falls. Record review of an incident report dated 01/22/25 indicated Resident #3 said she was sitting in her wheelchair getting a breathing treatment. She saw a bug crawling up the wall. She rolled to the wall, leaned forward. She forgot to lock the wheels. The wheelchair rolled out from under her. She landed flat on her bottom. Her back and tail bone hurts, 9/10 rating. Record review of an x-ray result for Resident #3 dated 01/22/25 indicated 1) x-ray of lumbar spine impression: No acute fracture or dislocation of the lumbar spine. 2) x-ray of sacrum/coccyx impression: No acute fracture or dislocation of the sacrum/coccyx. Record review of Resident #3's Fall Risk assessment dated [DATE] indicated the assessment was done due to a fall and she was at high risk for falls. Record review of Resident #3's care plan dated 01/24/25 indicated revisions to the care plan on 01/30/25 for 1/4 rails on the bed for safety/enabler. There was no care plan for the fall she had on 01/22/25. During an observation and interview on 04/23/25 at 09:20 a.m., Resident #3 was in her bed and the bed had 1/4 rails. There were no fall mats on the floor next to the bed and the bed was not in the lowest position. She said she had a fall a few months ago. She said the rails on her bed to help her with being able to turn in the bed. During an interview on 04/23/25 at 12:40 p.m., DON H said the MDS Nurse, the CN, the ADON, or herself were responsible for completing comprehensive care plans and updating the care plan as needed. DON H said her expectation would be for all residents at risk for falls or had a fall to have care plan initiated and updated with additional interventions. She said an air mattress would not increase a resident's risk for falls. She said interventions would be based on the resident's needs. During an interview on 04/23/25 at 01:30 p.m., the Administrator said nursing was responsible to complete all the care plans and updating them for the residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of a Falls and Fall Risk Managing policy revised March 2018 indicated: 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. Policy Interpretation and Implementation Fall Risk Factors: 2. Resident conditions that may contribute to the risk of falls include: a. fever; b. infection; c. delirium and other cognitive impairment; pain; d. lower extremity weakness; e. poor grip strength; f. medication side effects; g. orthostatic hypotension; h. functional impairments; i. visual deficits; and j. incontinence. 3. Medical factors that contribute to the risk of falls include: a. arthritis; b. heart failure; c. anemia; d. neurological disorders; and balance and gait disorders; etc. Resident-Centered Approaches to Managing Falls and Fall Risk (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling The Administrator and DON H were notified of the Immediate Jeopardy on 04/23/25 at 04:44 p.m. and was provided the Immediate Jeopardy template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The following Plan of Removal was submitted by the facility and accepted on 04/23/25 at 8:30 p.m. All items listed will be completed by 5:00 PM on 4/24/25 with continued follow-up for scheduled staff. 1. Administrator/DON initiated an in-service regarding policy and procedure for initiation of care plans for falls for licensed staff on 4/23/25. 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. The corporate MDS Nurse and the facility MDS Nurse initiated a review of all care plans for current accident/interventions in place to ensure it's on the care plan and a viable intervention. This action started on 4/23/25. 3. Administrator/DON initiated an update on all fall risk assessments that they are accurate, interventions are in place and care plan coincides. 4. The Administrator and DON all licensed nursing staff on fall policy procedure and interventions post fall. This action started on 4/23/25. 5. MDS Nurse and DON will ensure new admissions have appropriate care plans placed for risk assessments. All licensed nursing staff will in-serviced on implementing interventions for new admissions. This action started on 4/23/2025. 6. Administrator and DON were in-serviced on 4/24/2025 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. 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. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The Medical Director was made aware of the Immediate Jeopardy 04/23/25 at 5:15 p.m. 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 04/23/25 with attendance of Administrator, Director of Nursing, MDS Coordinator, Regional Director of Clinical Services, and Chief Operating Officer. This plan was initially implemented 04/23/25 and will be monitored through completion by corporate and regional staff. Plan of Removal completion date is 04/24/25 by 5:00 p.m. with continuation of oncoming staff and follow-up. Monitoring: Record review and interviews of completed: * Record review of the In-Services indicated the Administrator and DON H were in-serviced on 4/24/2025 by Regional Director of Clinical Services on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, and to notify regional/corporate staff of ALL falls/incidents care plans and are to notify regional/corporate staff of any discrepancies. * Record review of a resident list indicated the Corporate Nurse, DON H, and the MDS Nurse reviewed all care plans for current accident/interventions in place to ensure it's on the care plan and a viable intervention. Completed on 04/24/25. * Record review of a resident list indicated the Corporate Nurse, DON H, and the MDS Nurse initiated an update on all fall risk assessments that they are accurate, interventions are in place and care plan coincides. Completed on 04/24/25. * Record review of an In-Service signature sheet indicated the Administrator/DON H initiated an in-service regarding policy and procedure for initiation of care plans for falls for licensed staff on 4/23/25. 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. On 04/24/25 at 01:20 p.m. 13 licensed staff employed were in-serviced. One licensed staff on FMLA was left to in-service. * Record review of an In-Service signature sheet indicated the Administrator and DON H initiated an in-service for all licensed nursing staff on fall policy procedure and interventions post fall. On 04/24/25 at 01:20 p.m. 13 licensed staff employed were in-serviced. One licensed staff on FMLA was left to in-service. During an interview on 04/24/25 at 08:20 a.m., DON H said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, to notify regional/corporate staff of all falls/incidents care plans, and to notify regional/corporate staff of any discrepancies. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 08:25 a.m., the Administrator said he had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, initiation of care plans for falls, to notify regional/corporate staff of ALL falls/incidents care plans, and to notify regional/corporate staff of any discrepancies. During an interview on 04/24/25 at 08:35 a.m., the MDS Nurse said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 08:45 a.m., the ADON said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 09:15 a.m., RN A said she worked the 6a to 6p shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 09:25 a.m., LVN B said she worked the 6a to 6p shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 10:03 a.m., LVN C said she worked the 6p to 6a shift. She said she had in-services on 04/23/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 10:06 a.m., LVN D said she worked PRN. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 12:02 p.m., LVN E said she worked the 6p to 6a shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. During an interview on 04/24/25 at 12:49 p.m., RN F said she was the weekend RN. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. (continued on next page)

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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 Note: The nursing home is disputing this citation.	During an interview on 04/24/25 at 01:08 p.m., LVN G said she worked the 6p to 6a shift. She said she had in-services on 04/24/25 on Fall Risk Assessments, residents triggering for high risk for falls on assessment interventions were to be implemented, the Fall Policy and Procedure and interventions post fall, and initiation of care plans for falls. The Administrator and Regional Director of Operations were informed the Immediate Jeopardy was removed on 04/24/25 at 02:50 p.m. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrected system that were put into place.