STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675701	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Street Health Care Center	615 Lawrence St Tomball, TX 77375

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on interviews and record reviews, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 (Resident #1) of 6 residents reviewed for changes of condition. The facility failed to notify Resident #1's physician when she experienced a change of condition, including developing a small bump on the back of the head after she fell out of her wheelchair and hit her head on [DATE]. This failure placed residents at risk experiencing a delay in medical treatment and worsening of condition/symptoms. Record review of Resident #1 ' s face sheet dated [DATE], revealed he was admitted to the facility on [DATE] with diagnoses of Alzheimer ' s Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks); Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - and behavioral abilities to such an extent that it interferes with a person ' s daily life and activities); Type 2 Diabetes with Diabetic Chronic Kidney Disease (damaged blood vessels and other cells in the kidneys caused by diabetes); Restless Leg Syndrome (a condition that causes a very strong urge to move the legs); and Hypertension (or high blood pressure, is when the force of blood pushing against your artery walls is consistently too high). Record review of Resident #1 ' s MDS assessment dated [DATE], revealed no interview for mental status was conducted, which indicated the resident was rarely or never understood, and rarely or never made decisions regarding daily life. Resident #1 required limited assistance with bed mobility, transfer, eating, and extensive assistance with toileting. The resident required one-person physical assist with bed mobility, transfer, eating and toileting. Further review of the MDS did not reveal whether the resident used a wheelchair. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan revealed she had an Actual Communication Problem related to being Hard of Hearing. Interventions included a communication board for the resident to use to communicate; ensure availability and functioning of adaptive communication equipment. Other interventions included allowing the resident adequate time to respond; repeat as necessary; do not rush; request clarification from the resident to ensure understanding; face when speaking; make eye contact; turn off TV/radio to reduce environmental noise; ask yes/no questions if appropriate; use simple, brief, consistent words/cues; use alternative communication tools as needed. The resident was at risk for falls related to poor safety awareness and weakness. The resident had impaired cognitive function and impaired thought processes related to Alzheimer's Disease and Dementia. Interventions included observations for any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Interventions included fall mat to the floor when in bed, and a medication review. The resident had a 'Do Not Resuscitate' code status, per her hospice provider. Interventions included not starting CPR if the resident was found with no pulse, respirations, or blood pressure. Record review of the facility 24-hour report, dated [DATE], did not reveal mode of communication used to make appropriate notifications, information provided during notifications, dates, times, individuals notified, or directives provided after notifications made. Review of the progress notes also did not reveal notification to hospice provider. Further review of the 24-hours report revealed the following: Resident was attending church service in dining room. A large group was gathered with loud singing for a long length of time. Resident was sitting in her locked w/c when fell back still in w/c. Head to assessment done only has a small bump to back of head skin intake and ice was applied. Neuro ' s started NP, RP and DON notified. Record Review of Resident #1 ' s Progress Notes, did not reveal mode of communication used to make appropriate notifications, information provided during notifications, dates, times, individuals notified, or directives provided after notifications made. Review of the progress notes also did not reveal notification to hospice provider. Further review of the progress note revealed, at 3:30 PM on [DATE], did not reveal mode of communication used to make appropriate notifications, information provided during notifications, dates, times, individuals notified, or directives provided after notifications made. Review of the progress notes also did not reveal notification to hospice provider. Further review of the progress notes revealed, LVN A wrote Resident was attending church service in dining room. A large group was gathered with loud singing for a long length of time. Resident was sitting in her locked w/c when fell back still in w/c. Head to assessment done only has a small bump to back of head skin intake and ice was applied. Neuro ' s started NP, RP and DON notified. In an interview with the DON on [DATE] at 2:06 PM, she said if a resident fell , hit their head, and sustained an injury, the nurses were to notify the resident's NP, family, and hospice, if necessary. She said the nurse was also responsible for documenting who they spoke to, whether it was the NP, the physician in charge or, the on call after hours physician. She said they also documented notification to the RP, hospice, nurse manager, who they spoke to and whatever orders or information given to them at the time of the notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Nurse Practitioner on [DATE] at 2:42 PM, she said she thought she was contacted by the facility on [DATE] regarding Resident #1 falling. She said if the facility had told her the resident had a head injury, or a small bump on her head, she would have sent the resident out for a CT scan. She said she could not recall who contacted her regarding the resident's fall. She said she was currently reviewing her notes at that time and could not find any information on the resident's fall on [DATE]. She said if she did not have notes of the fall, no notification was made to her. She said she visited the facility every other day and remembered hearing about the resident's fall from the resident ' s nurse. She said she just reviewed everything entered in the resident's electronic health record, with the facility, regarding the fall incident on [DATE]. She said if she had been contacted, she would have ordered for the resident to be sent to the hospital for a CT scan. She said the resident was at risk for internal head bleeding and confusion by not receiving emergency medical services on [DATE]. She said it would have been important to send a resident whose baseline mental status was confused out to the hospital for evaluation because they would not be able to tell if there was anything going on internally. In an interview with the Weekend Supervisor on [DATE] at 3:14 PM, she said the nurse should have contacted the NP to get further instruction after Resident #1 fell . She said she did not know the resident had a small bump on the back of her head after she fell . She said the nurse should have contacted the NP and the DON and notified them about the bump on the back of Resident #1's head. She said LVN A was responsible for completing tasks related to the resident ' s fall because she was the primary nurse for the resident. She said the DON would have been responsible for reviewing the documentation from the incident. She said she could not recollect whether she notified the DON via text message or phone call about the resident's fall. She said when an incident occurred over the weekend, they were supposed to call the on-call phone to make notification to the on-call person. She said she did not call the on-call phone and did not know whether LVN A called the on-call phone to notify on call management about the resident's fall. She said if Resident #1 fell , hit her head, developed a small bump on the back of the head, and was not sent to the hospital for evaluation, the resident was risk of a subdural hematoma or an internal bleed. In an interview with LVN A on [DATE] at 10:53 AM, she said she sent a message to the NP regarding the resident falling. She said she had proof she sent a text message to the NP but could not remember when she sent the text message. She said she told the NP the resident fell and hit her head, but she was okay. She said the NP gave orders to continue to monitor the resident. She said she did not tell the NP the resident had a small bump on the back of her head because she did not initially have the bump when she notified the doctor. She said she did not know how long it was between the time she notified the NP of the fall and the time the resident developed the small bump on the back of the resident's head. She said when a physician gave an order for monitoring, it was for staff to monitor for changes in the resident's condition. She said she followed the NP ' s directives to monitor the resident. She said she said immediately began neuro checks and continued to monitor the resident. She said she did not think about notifying the NP the resident developed a small bump on the back of her head, after falling. She said she did not think the resident was at any sort of risk because she said a man who witnessed the resident ' s fall told her the resident may have hit her shoulder or another body part on the way down to the floor. She said that may have softened the blow if the resident did hit her head. She said she did not think the resident was put at any risk because the resident did not suffer from a bad fall. She said she probably should have notified the NP the resident had a small bump on her head. She said she could not recall whether she contacted to hospice to notify them of the incident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on [DATE] at 11:58 AM, she said they went through the resident's chart the next day, as a whole team. She said at that time, nothing stuck out to her about the nurse's documentation or concern because she saw the nurse noted she made notification. She said from what she read, they notified the NP and there were no new orders. She said she did not ask any of the nurses if the NP was notified about the bump on the back of the resident's head. She said she was notified by either LVN A or the Weekend Supervisor of the resident's fall on [DATE]. She said LVN A should have also communicated to the doctor the resident had a bump on the back of her head when LVN A notified the NP of the incident. She said the only thing that was concerning to her was LVN A did not tell Resident #1's NP the resident hit her head or had a small bump on the back of her head. She said the resident could have been at risk for not receiving appropriate care due to the physician not being notified the resident had a bump on the back of her head. Interview with the Administrator at 1:04 PM on [DATE], she said the assigned nurse was supposed to notify the DON, NP, family and then hospice. She said it was the responsibility of the nurse providing care to the resident to continue the care and communicate on behalf of the facility because they were the ones with the rapport with the family and doctor for that resident. She said as far as documentation, she reviewed the change of condition form and made sure all the pertinent information was there. She reviewed the incident/accident report to see what happened, if the nurse did an assessment, who the nurse notified, and reviewed the summary of the incident. She said the nurse was also to document any other assessments completed, whether neuro checks had been done, new orders received, and any changes of condition identified in the resident. She said she did not feel the resident was at risk or that the outcome would have been changed in any way because she had a bump on her head. She said the staff typically did not document anything when they communicated with physicians, unless a new order was given, or if they were asked to monitor the resident. She said the NP just said ' okay ' in response to being notified about the resident's fall. She said she had spoken to the NP since the incident and the NP said she would not have sent the resident out to the hospital. She said while the situation was handled appropriately, there was always room for improvement. She said the only thing she felt could have been improved on was more detail in documentation because documentation was key. She said she spoke the doctor about the situation and the doctor said he would not have sent the resident out, even if he had been notified the resident fell and had a small bump on her head. Record review of the undated policy, titled, Fall Prevention Program revealed the following: .9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident ' s care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. Record review of the policy, revised February 2021, titled, Change in a Resident ' s Condition or Status revealed the following: 1. The nurse will notify the resident ' s attending physician or physician on call when there has been a(an): a. accident or incident involving the resident .3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form .8. The nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated policy, titled, Notification of Changes revealed the following: The facility must inform the resident .consult with the resident ' s physician and/or notify the resident ' s family member or legal representative when there is a change requiring such notification .Circumstances requiring notification include: 1. Accidents a. Resulting in injury. B. Potential to require physician intervention . Record review of the undated policy, titled, Head Injury revealed the following: It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury. Policy Explanation and Compliance Guidelines: 1. Assess resident following a known, suspected, or verbalized head injury. The assessment tool shall include, at a minimum: a. Vital Signs. b. General condition and appearance. c. Neurological evaluation for changes in: i. physical functioning ii. Behavior iii. Cognition iv. Level of consciousness v. Dizziness vi. Nausea vii. Irritability viii. Slurred speech or slow to answer questions d. Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell or bleeding. e. Any injuries to head, neck, eyes, or face, including lacerations, abrasions, or bruising. f. Pain Assessment . 3. Notify physician and follow orders for care. a. Provide information from physical assessment. b. Describe how injury occurred and how situation has been managed so far. c. Report any recent medication changes or use of antiplatelet/anticoagulant medications. d. Any recent lab or diagnostic test results. 4. Perform neuro checks as indicated or as specified by the physician . 6. Continue monitoring for 72 hours following the incident or until the resident is asymptomatic for a period of time specified by the physician. 7. Notify family and document all assessment, actions, and notifications. Record review of the policy, revised [DATE], titled, Falls-Clinical Protocol revealed the following: 5. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc . (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Falls should be categorized as: a. Those that occur while trying to rise from a sitting or lying to an upright position; b. those that occur while upright and attempting to ambulate; and c. other circumstances such a sliding out of a chair or rolling from a low bed to the floor. 7. Falls should also be identified as witnessed or unwitnessed events. Monitoring and Follow-Up 1. The staff, with the physician ' s guidance, will follow up on any fall with associated injury until the resident is table and delayed complications such as fracture or subdural hematoma have been ruled out or resolved. a. Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to several weeks after a fall. 2. The staff and physician will monitor and document the individual ' s response to interventions intended to reduce falling or the consequences of falling . Record review of the undated policy, titled, Incident and Accidents revealed the following: It is the policy of this facility to utilize the Risk Management Module in the electronic health records to report, investigate, and revie wany accidents or incident that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Definitions: Accident refer to any unexpected or unintentional incident, which results or may result in injury or illness to a resident . Policy Explanation The purpose of incident reporting can include: Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care .Meeting regulatory requirements for analysis and reporting of incidents and accidents. Compliance Guidelines .5. The following incidents/accidents require an incident/accident report but are not limited to: .Equipment malfunction; Falls; Observed accidents/incidents . 6. In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm. 7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so . 8. The supervisor or other designee will be notified of the incident/accident . 9. The nurse will contact the resident ' s practitioner to inform them of the incident/accident, report any injuries or other finding, and obtain orders, if indicated, which may include transportation to the hospital dependent upon the nature of the injury(ies). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10. In the event of .or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner . 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions. 15. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and/or Administrator.

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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 - Minimal harm or potential for 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** 47479 Based on interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices based on the comprehensive assessment for 1 (Resident #1) of 6 residents reviewed for quality of care. -The facility failed to complete an appropriate assessment for Resident #1 after she fell out of her wheelchair and a small bump to the back of the head was sustained. -The facility failed to send Resident #1 to the hospital after she fell out of her wheelchair, hit her head and developed a small bump on the back of her head. These failures could place residents at risk of not receiving needed care and services to meet their physical, mental, and psychosocial needs. Findings include: 1. Record review of Resident #1's face sheet dated [DATE], revealed he was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks); Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - and behavioral abilities to such an extent that it interferes with a person's daily life and activities); Type 2 Diabetes with Diabetic Chronic Kidney Disease (damaged blood vessels and other cells in the kidneys caused by diabetes); Restless Leg Syndrome (a condition that causes a very strong urge to move the legs); and Hypertension (or high blood pressure, is when the force of blood pushing against your artery walls is consistently too high). Record review of Resident #1's MDS assessment dated [DATE], revealed no interview for mental status was conducted, which indicated the resident was rarely or never understood, and rarely or never made decisions regarding daily life. Resident #1 required limited assistance with bed mobility, transfer, eating, and extensive assistance with toileting. The resident required one-person physical assist with bed mobility, transfer, eating and toileting. Further review of the MDS did not reveal whether the resident used a wheelchair. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan revealed she had an Actual Communication Problem related to being Hard of Hearing. Interventions included a communication board for the resident to use to communicate; ensure availability and functioning of adaptive communication equipment. Other interventions included allowing the resident adequate time to respond; repeat as necessary; do not rush; request clarification from the resident to ensure understanding; face when speaking; make eye contact; turn off TV/radio to reduce environmental noise; ask yes/no questions if appropriate; use simple, brief, consistent words/cues; use alternative communication tools as needed. The resident was at risk for falls related to poor safety awareness and weakness. The resident had impaired cognitive function and impaired thought processes related to Alzheimer's Disease and Dementia. Interventions included observations for any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Interventions included fall mat to the floor when in bed, and a medication review. The resident had a 'Do Not Resuscitate' code status, per her hospice provider. Interventions included not starting CPR if the resident was found with no pulse, respirations, or blood pressure. Record review of Resident #1's orders, dated [DATE], revealed no orders for neuro checks or fall risk interventions on [DATE]. Further review of orders revealed the resident was admitted to hospice for routine care on [DATE]. Interventions included pain monitoring using the pain numeric scale (,d+[DATE]) or PAINAD (pain assessment in advanced dementia). Record review of the facility 24-hour report, dated [DATE], revealed the following: Resident was attending church service in dining room. A large group was gathered with loud singing for a long length of time. Resident was sitting in her locked w/c when fell back still in w/c. Head to assessment done only has a small bump to back of head skin intake and ice was applied. Neuro's started NP, RP and DON notified. Record Review of Resident #1's Progress Notes, revealed no mode of communication used to make appropriate notifications, information provided during notifications, dates, times, individuals notified, or directives provided after notifications made. Review of the progress notes also did not reveal notification to hospice provider. Further review of the progress note revealed, at 3:30 PM on [DATE], LVN A wrote Resident was attending church service in dining room. A large group was gathered with loud singing for a long length of time. Resident was sitting in her locked w/c when fell back still in w/c. Head to assessment done only has a small bump to back of head skin intake and ice was applied. Neuro's started NP, RP and DON notified. Record review of the resident's Change in Condition, dated [DATE] did not reveal Resident #1's vital signs at the time the resident was assessed on [DATE]. Further review of the Change in Condition revealed, at 5:01 PM on [DATE], LVN A documented the following vital signs for Resident #1 At the time of this evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure ,d+[DATE] - [DATE] at 9:13 AM Pulse: 70 - [DATE] at 9:18 AM RR: 16.0 - ,d+[DATE] at 8:38 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Temp: 98.3 - [DATE] at 8:40 AM Pulse Oximetry: O2 99.0% - [DATE] at 8:46 AM Further review of the Change in Condition revealed, no responses to questions regarding the resident's pain was documented. Also, no responses to questions behavioral, respiratory, cardiovascular, abdominal, skin, and neurological status evaluations were documented. Record Review of Neuro Checks revealed, vital signs and neuro checks were to be completed every 15 minutes for one hour; every 30 minutes for one hour; every hour for four hours; then, every four hours for 24 hours. [DATE] at 3:30 PM, RN a noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-87; Respiration-18; Temperature-97.7. [DATE] at 3:45 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-88; Respiration-18; Temperature-97.7. [DATE] at 4:00 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-86; Respiration-18; Temperature-97.7; Initials. [DATE] at 4:15 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-86; Respiration-18; Temperature-97.7. [DATE] at 4:45 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-84; Respiration-18; Temperature-97.7. [DATE] at 5:15 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-86; Respiration-18; Temperature-97.7. [DATE] at 6:15 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-88; Respiration-18; Temperature-97.6. [DATE] at 7:15 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-90; Respiration-18; Temperature-97.6. [DATE] at 8:15 PM, RN B noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-87; Respiration-18; Temperature-97.7. (continued on next page)

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	675701	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Street Health Care Center	615 Lawrence St Tomball, TX 77375

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 9:15 PM, RN B noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-84; Respiration-18; Temperature-97.7. [DATE] at 1:15 AM, RN B noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-78; Respiration-18; Temperature-97.7. [DATE] at 5:15 AM, RN B noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-74; Respiration-18; Temperature-97.3. [DATE] at 9:15 AM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-78; Respiration-18; Temperature-97.6. [DATE] at 1:15 PM, RN A noted the resident was fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-76; Respiration-18; Temperature-97.6. [DATE] at 5:15 PM, RN A noted the resident fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-78; Respiration-18; Temperature-97.6. [DATE] at 9:15 PM Fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-78; Respiration-18; Temperature-98; Initials-RN B [DATE] at 1:15 AM Fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-73; Respiration-18; Temperature-97.9; Initials-RN B [DATE] at 5:15 AM Fully conscious; movement of all 4 extremities; hand grasps equal and strong; fixed left and right pupil reactions; clear speech; BP-,d+[DATE]; Pulse-87; Respiration-18; Temperature-97.9; Initials-RN B Record review of Hospice Nursing Clinical Note, dated [DATE], revealed the following: The resident was noted to have a hearing impairment, confusion, and disorientation. Summary: LVN B stated pt fell yesterday while trying to get out of w/c and has small bump on back of head. Facility doing neuro checks on pt. All WNL for pt. Assessment complete, vitals stable, blood pressure on the lower side of normal LVN B will recheck and continue to monitor . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an undated text message from RN A , revealed the following: On [DATE], RN was called in to dining room by nurse aide. Upon arrival it was clear the resident, [Resident #1] was sprawled out on the floor next to her wheelchair lying face up. RN assessed resident head to toe before moving her. Because RN knows resident well, was able to quickly realize she was neurologically at her baseline from before this incident. She was able to track with both eyes, follow commands, move all extremities with no signs of pain. Skin assessment revealed no bleeding, skin warm dry and intact. Only a small bump of about 0.75 inch on back of head close to base of skull .It was reported to nurse by several bystanders that resident hit head after falling out of the wheelchair .RNs clinical decision she was safe to try sitting up. Then after explained what was going to happen next, RN and aide assisted her back into her chair .RN then wheeled resident back to nurse's station where vitals were checked by nurse in charge of her care and neuros protocol started . In an anonymous interview on [DATE] at 9:50 AM [DATE], they said they were present in the dining area of the facility when Resident #1 fell and hit her head. They said they could not remember the exact date or time, but the incident happened a few weeks ago, and a group was at the facility having church service in the dining area. They said the resident was not able to respond or actively participate in the activities taking place. They said the resident was sitting in a wheelchair near a table when the resident flipped backwards in her wheelchair. They said the resident's head hit the floor and it made a very loud sound. They said at the time the resident flipped backwards in the wheelchair, there were no facility staff present in the dining area. They said there were several people part of the group providing the service to residents, and several residents present, but they could only remember the resident who was right next to them at the time of the incident. They said the one resident right next to them at the time and everyone else in the dining area was shocked. They said someone ran and got facility staff to come help the resident. They said three women; one young and two older, all three were Hispanic or White, immediately, came into the dining area, picked the resident up off the floor, and put her back in her wheelchair. They said they told the staff they should not have moved the resident and that they needed to call 911. They said the resident next to them said something to the staff and was concerned about the staff picking the resident up off the floor immediately too. They said the women responded and said they were the professionals and knew what they were doing. They said once the three staff got the resident up, and into her wheelchair, one checked her pulse, and then took the resident out of the dining area. They said the facility did not call 911. They said they remained at the facility about 30 minutes after the resident's fall and never saw an ambulance show up. They said they were concerned because the resident should not have been moved right after hitting her head on the floor. In an interview with Resident #2 on [DATE] at 10:08 AM, she said she attended the church services in the dining area on Sundays. She said she saw Resident #1 fall in the dining area a few weeks back. She said she could not remember exactly when this took place. She said she did not see what was happening with the resident before she fell . She said she saw the resident go backwards out of her wheelchair onto the floor. She said the resident's head made such a loud noise when she hit the floor, she got worried. She said it was a lot of people in the dining area and everybody was concerned because the noise was so loud from the resident hitting her head. She said three staff came in and quickly got the resident up off the floor and back into her wheelchair. She said the staff did not do anything to the resident before they got her off the floor. She said they immediately picked her up. She said she did not know if a nurse checked the resident out after they got her back into her wheelchair. She said she was sure a nurse did not do anything to check on the resident before they moved her. She said it was a lot of people in the dining area when the resident fell and saw what happened, but she did not think there were any staff present when the resident fell . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Med Aide A on [DATE] at 12:55 PM, she said herself, CNA A, and a nurse were the staff that went into the dining area to help after Resident #1 fell out of her wheelchair. She said she could not remember exactly which nurse it was, but she thought it was RN A. She said the resident was lying on the ground on her back and the resident pointed to her side. She said the resident was not saying anything. She said the resident was not bleeding and did not have any visible injuries. She said she saw the nurse touching different parts of the resident's body. She said the nurse was probably checking for pain. She said then, the three of them (Med Aide A, CNA A and the nurse) grabbed the resident by her pants to pick her up off the ground and placed her back in her wheelchair. She said she thought the nurse might have checked the resident's vitals after they got the resident back into her wheelchair, but she was not sure. She said after they got the resident back into her wheelchair, she went back to the B hall because she had to finish administering meds. She said she did not have to write a statement or complete an incident report because she did not witness anything, and just went there to help get the resident up off the floor. She said staff were not to move a resident until a nurse said it was okay. She said the nurse decided it was okay to pick the resident up and put her back in her wheelchair. In an interview with CNA A on [DATE] at 1:09 PM, she said she was working on the day ([DATE]) Resident #1 fell out of her wheelchair. She said when she made it to the dining area the resident was lying on the ground, on her side. She said she did not observe any bleeding, nor was the resident crying. She said the resident was not speaking at all. She said the resident was mostly nonverbal and only spoke when she felt like it, so it was normal for her not to say anything. She said the resident had a knot on the back of her head, so she went to get an ice pack and a pillow for the resident. She said she knew the resident had a knot on the back of her head because the nurse said the resident did. She said the nurse was RN A. She said when she came back with the ice and the pillow, the nurse said it was okay to get the resident off the floor. She said she did not see RN A take vitals or assess the resident. She said she believed RN A at least assessed the resident because RN A gave the okay to get the resident up. She said CNA A, Med Aide A and RN A got the resident off the floor using her clothes. She said no staff was allowed to move a resident after a fall, unless a nurse said it was safe. She said RN A or the resident's assigned nurse could have taken the resident's vitals after they got the resident back into her wheelchair. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on [DATE] at 1:29 PM, she said she was in the middle of doing blood sugar checks on resident's when she found out Resident #1 fell . She said the resident was in the dining room. She said sometimes on Sundays, they were in the dining area for hours having church service. She said the resident had Dementia and Alzheimer's, and her attention span was not that long. She said the only thing she could think of as the cause for the resident's fall, was the resident got tired and wanted to go back to her room. She said the Weekend Supervisor and RN A were the nursing staff that went to the dining room after the resident fell . She said she thought one of the aides came and told her Resident #1 fell , but she was not sure. She said when she went into the dining area, she saw the resident sitting in her wheelchair and talking. She said she saw a nurse have the resident squeeze the nurse's finger, follow their finger with her eyes, and touch the resident's body to check for pain. She said she could not remember which nurse it was but felt like it was the Weekend Supervisor. She said she did not see a nurse check Resident #1's vitals. She said Resident #1 also had a small bump in the back of her head, but never complained of pain. She said she immediately began doing neuro checks on the resident, since she was her assigned nurse. She said neuro checks were performed for 24 hours. She said she was the one to place the call to the nurse practitioner, and the nurse practitioner said to continue to monitor the resident for any changes. She said she did not remember who she spoke to when she contacted the nurse practitioner. She said there were no significant changes in the resident's vitals or complaints of pain. She said the night shift staff was notified about the resident's incident, continued neuro checks and monitoring for changes. She said when a resident fell and had a head injury, she would do an assessment, call the nurse practitioner, begin neuro checks, and monitor the resident for changes in condition. She said she would ask the resident about pain, feel their head, see if there was any active bleeding. She said she would check their blood pressure, pulse, and look for rapid breathing. She said she would talk to the resident, see if they were able to follow her finger. She said Resident #1 was unable to tell you date/time but would tell if she was in any pain. In an interview with RN C on [DATE] at 1:50 PM, she said she worked at the facility for three years. She said if she was alerted a resident fell and hit their head, she would get help and then call 911. She said if the resident had any signs of a hematoma, they would be sent to the hospital. She said she would call emergency services, call the resident's family, NP, MD, administrator, and DON. She said she would also document a change in condition, incident report and fall assessment in the resident's electronic health record. In an interview with RN B on [DATE] at 1:53 PM, she said if she was notified a resident fell , hit their head, and had a small bump on back of their head, she would send the resident out to the hospital immediately via emergency services. She said it did not matter if the resident was on hospice. She said she would send the resident to the hospital and let hospice know after the fact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on [DATE] at 2:06 PM, she said she worked at the facility for three years. She said if a resident fell , hit their head, and sustained an injury, it was her expectation of the nurses not to move the resident. She said it was her expectation for the nurses to contact emergency services to transport the resident to the hospital, identify if the resident was on blood thinners, and send them out. She said the nurses were to also notify the resident's NP, family, and hospice, if necessary. She said the nurses would do neuro checks on the resident for three days; go through recent lab work; have a care plan meeting to see what was going on; and make changes to interventions. She said the nurse would fill out an incident report, change of condition, and other post fall documentation in the resident's electronic health record. She said all the documentation should be completed in a timely manner. She said if there was a change of condition observed after the fall, the resident would be sent to the hospital. She said even if the resident had a head injury after a fall, they would call hospice to notify, but the resident still needed to be sent to the hospital. She said the hall charge nurse would enter the incident information in a risk management report, complete a fall risk assessment, and a post fall assessment. She said the nurse was supposed to document what happened; how it happened; pain assessment; injuries; witnesses; any other notes and a signature section at the end. She said the nurse was also responsible for documenting who they spoke to, whether it was the NP, the physician in charge or, the on call after hours physician. She said they also documented notification to the RP, hospice, nurse manager, who they spoke to and whatever orders or information given to them at the time of the notification. She said there was no time it would be okay for a staff to move a resident with a head injury. She said even the fall was unwitnessed, if there was an obvious injury they needed to be kept as still as possible until emergency services arrived. She said if a resident fell and hit their head and the sound from them hitting their head was loud enough to be heard, and the resident had a small bump, that would still be considered a head injury. She said the resident needed to be sent to the hospital. She said a resident who fell , hit their head, and had a head injury not receiving emergency medical services were at risk of a bleed, contusion, concussion, hematoma under the skin, or something that would require a CT scan right away to catch. In an interview on [DATE] at 2:42 PM with the Nurse Practitioner, she said she thought she was contacted by the facility on [DATE] regarding Resident #1 falling. She said if the facility had told her the resident had a head injury, or a small bump on her head, she would have sent the resident out for a CT scan. She said she could not recall who contacted her regarding the resident's fall. She said she was reviewing her notes at that time and could not find any information on the resident's fall on [DATE]. She said if she did not have notes of the fall, no notification was made to her. She said she visited the facility every other day and remembered hearing about the resident's fall from the resident's nurse. She said she just reviewed everything entered in the resident's electronic health record, with the facility, regarding the fall incident on [DATE]. She said if she had been contacted, she would have ordered for the resident to be sent to the hospital for a CT scan. She said the resident was at risk for internal head bleeding and confusion by not receiving emergency medical services on [DATE]. She said it would have been important to send a resident whose baseline mental status was confused out to the hospital for evaluation because they would not be able to tell if there was anything going on internally. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Weekend Supervisor on [DATE] at 3:14 PM, she said she worked at the facility for a little over a year. She said it was her expectation for nurses to provide immediate care to a resident who fell and hit their head. She said the nurses were supposed to check vitals, ensure the resident was not in any distress, and call the doctor to tell them what transpired. She said when the nurse got orders from a physician, the nurse should document in the electronic health record, then make notifications to the family and the DON. She said the nurse needed to do an assessment and find out if the resident was on any blood thinners. She said the nurse should check the resident's vital signs, level of consciousness, blood pressure, pulse, respirations, and pupils during an assessment. She said the nurse should assess the resident for pain and ask them if they were in pain. She said the nurse should do a skin assessment and check for range of motion. She said to check for range of motion, the nurse should ask the resident to move their arms and legs, see if they can stand, and bend over. She said if the resident was lying on the floor, the nurse needed to check for range of motion while the resident was still on the floor. She said if the resident had not broken any bones, the nurse and other staff could get them up off the floor, and into a chair or wheelchair. She said the nurse could also get the resident back in their bed, perform another assessment, begin neuro checks at that point, then contact the doctor. She said if the resident had a head injury it was standard for the facility to call the resident's doctor. She said if the doctor had a standing order for residents with a head injury to be sent out to the hospital, then they would send the resident out. She said she did not know what the facility's policy was on resident's who fell and sustained a head injury. She said she had not looked at the policy. She said she was working on [DATE] at the time Resident #1 fell . She said she was doing patient care when she came out of a resident's room, and a family member told her a resident had fallen. She said the nurse and the resident were not in the dining area by the time she found out about the incident. She said everything was already over and handled. She said the nurse should have contacted the NP to get further instruction after Resident #1 fell . She said she believed that it was only family members and residents in the dining hall at the time of the resident's fall. She said residents could not provide statements due to their inability to accurately recall or perceive things. She said there were no statements gathered from anyone who witnessed the incident. She said she did not remember speaking to any other staff to find out what happened and what was done for the resident. She said she only spoke to LVN A about what she had done with Resident #1. She said LVN A told her the resident had been assessed. She said she did not ask LVN A who assessed the resident. She said if LVN A did not assess Resident #1 then RN A likely assessed her. She said if RN A assessed the resident, she would have given LVN A the vital signs and other observations from her assessment. She said if RN A assessed the resident, LVN A would have been the nurse responsible for documenting RN A's assessment, what happened, and the care provided to the resident, according to RN A, in Resident #1's electronic health record. She said she did not know the resident had a small bump on the back of her head after she fell . She said the nurse should have contacted the NP and the DON and notified them about the bump on the back of Resident #1's head. She said LVN A was responsible for completing tasks related to the resident's fall because she was the primary nurse for the resident. She said the DON would have been responsible for reviewing the documentation from the incident. She said she could not recollect whether she notified the DON via text message or phone call about the resident's fall. She said when an incident occurred over the weekend, they were supposed to call the on-call phone to make notification to the on-call person. She said she did not call the on-call phone and did not know whether LVN A called the on-call phone to notify on call management about the resident's fall. She said if Resident #1 fell , hit her head, developed a small bump on the back of the head, and was not sent to the hospital for evaluation, the resident was risk of a subdural hematoma or an internal bleed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN A on [DATE] at 10:53 AM, she said she was not the nurse who performed an assessment on Resident #1 right after the resident fell . She said she thought the Weekend Supervisor performed the assessment, but it was RN A who performed the assessment. She said RN A told her she was going to put all her information from her assessment of the resident in her electronic health record. She said she asked RN A if she assessed the resident and RN A told her yes. She said she sent a message to the NP regarding the resident falling. She said she had proof she sent a text message to the NP but could not remember when she sent the text message. She said she told the NP the resident fell and hit her head, but she was okay. She said the NP gave orders to continue to monitor the resident. She said she did not tell the NP the resident had a small bump on the back of her head because she did not initially have the bump when she notified the doctor. She said she did not know how long it was between the time she notified the NP of the fall and the time the resident developed the small bump on the back of the resident's head. She said when a physician gave an order for monitoring, it was for staff to monitor for changes in the resident's condition. She said she followed the NP's directives to monitor the resident. She said she said immediately began neuro checks and continued to monitor the resident. She said she did not think about notifying the NP the resident developed a small bump on the back of her head, after falling. She said she did not think the resident was at any sort of risk because she said man who witnessed the resident's fall told her the resident may have hit her shoulder or another body part on the way down to the floor. She said that may have softened the blow if the resident did hit her head. She said she did not think the resident was put at any risk because the resident did not suffer from a bad fall. She said she probably should have notified the NP the resident had a small bump on her head. She said she could not recall whether she contacted to hospice to notify them of the incident. In an interview with RN A on [DATE] at 11:19 AM, she said she worked at the facility for three years. She said she was clinically able to assess a resident from head to toe. She said if she was assessing a resident after a fall, she would do a neurological assessment. She said a neurological assessment consisted of checking for seizures, fo