STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Place	1321 Park Bayou Dr Houston, TX 77077

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 - Immediate jeopardy to resident health or safety 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** 45328 Based on interviews, observation, and records reviewed, the facility failed to immediately consult with the resident's physician and notify the resident representative when there was a significant change in the resident's condition or need to alter treatment significantly for 1 of (Resident 1) of 9 residents reviewed for notify of changes. -LVN A failed to report Resident #1's change in condition to the MD/NP after she fell on [DATE] when CNA B performed a two person transfer alone. Resident #1 suffered a right transverse impacted fracture of the proximal humeral metaphysis (broken upper arm) and a right periprosthetic fracture (broken knee bone). On 09/21/24 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/24/24, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of not receiving immediate medical attention and required notifications being made when there is a change in their condition, which could lead to worsening of conditions and serious injury or harm. The findings included: Record review of Resident #1's Face Sheet, dated 08/16/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included aphasia (language disorder that affects speaking or understanding language), hemiplegia (one sided paralysis or weakness caused by brain or spinal cord problems) affecting right dominant side, and muscle wasting and atrophy (loss of muscle leading to shrinking and weakening). Record review of Resident #1's Admission MDS Assessment, dated 05/30/24, revealed a BIMS score of 6, indicating severe cognitive impairment. Further review revealed she was dependent (the assistance of 2 or more helpers was required for the resident to complete the activity) on toileting, showering/bathing, dressing, sit-to stand, and chair/bed-to-chair transfer. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675777	A. Building B. Wing	09/24/2024

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, effective date 05/20/24, revealed the resident had impaired bed mobility, and a communication problem and was rarely understood in ability to express ideas and wants. Further review revealed resident was at risk for falls related to diagnosis of right hemiparesis. Goals included transfers to be completed by staff (transfer boards/lift) as required over the next 90 days and interventions included using the transfer board/lift devices. The care plan did not reflect what type of board/lift device was to be used or how many staff were to assist with the transfer. Record review of Nurse A's nursing note late entry entered 08/07/24 at 21:57 p.m. (9:57p.m.) with an effective date of 08/06/24 at 19:20 p.m. (7:20p.m.) revealed he .heard CNA shouting to my name for help around 1900ish (7ish), I hurried to her location and found resident's not in cloths [sic]hanging on sit to stand both hands in air and legs dropped on the floor. [Nurse A] and CNA lowered resident to floor and lifted her with the Hoyer lift mat to the shower chair. As at time writer assessed resident's body there was no [sic] any bruise noted. Record review of incident/accident reports revealed for Resident #1 revealed the following: *8/07/24 completed by Nurse B at 7:46 a.m., revealed the resident's leg dropped during transfer with sit to stand lift for shower and resident was noted with bruise to left leg. Resident denied pain and there was no apparent injury at this time. *8/07/24 completed by the DON at 16:23 p.m. (4:23 p.m.), revealed she assessed the resident after the family member verbalized concern about resident care. Upon assessment observed bruise on right shoulder, right lower arm, and leg. When repositioned resident, resident verbalized pain and pain medication was administered. The NP was notified and said she was going to order x-ray and a pain medication. The type of incident/injury noted was fall while bring assisted. Record review of nursing note , entered by Nurse C, dated 08/08/24 at 9:50 a.m., revealed the resident was sent out to the hospital on 08/08/24. Record review of hospital Facesheet, print date 08/10/24, revealed Resident #1 was sent out to the hospital on 08/08/24. Record review of the Resident #1's hospital discharge paperwork, dated 08/12/24, reflected in part .per orthopedics humerus fracture, nonsurgical, keep in sling. Further review revealed since Resident #1 was immobile and bedbound since her CVA in February there was no benefit of surgical repair of periprosthetic fracture. Resident #1 returned to the facility after discharge on 08/12/24. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 08/16/24 at 9:45 a.m. of several video footage clips, dated 08/06/24, revealed the fall incident began at 19:02:20 p.m. and ended at 19:08:49 p.m. The footage revealed CNA B attempted to use a sit to stand lift (sitting down and standing up from a seat without using your hands for assistance) to transfer Resident #1 from the bed to the shower chair located in the bathroom. During the transfer, Resident #1's arms started sliding up and back from the support vest (helps support upper body) placed around the resident's back and under the arms as CNA B started to move the lift forward and away from the bed. CNA B went towards the bedroom door, returns quickly, stands to the left of the resident, supporting her by her left arm until Nurse A enters the room and helps her lower Resident #1 to the floor. Observation and attempted interview on 08/30/24 at 8:50 a.m., revealed Resident #1 was lying in bed watching television. Resident said yes when asked if she was fine. Resident said yes, yes when asked if she remembered the incident when she fell , and then her hands and voice started shaking. Interview was ended as not to upset the resident. During an interview on 08/16/24 at 10:37 a.m., the Administrator said CNA B disclosed she used the sit to stand lift to transfer Resident #1 when she knew to use the Hoyer lift. She said she transferred the resident on her own when she knew she needed to have another person with her. She said lift transfers required two persons. She said CNA B said she just wanted to hurry and give the resident a shower for the day. She said CNA B said the sit to stand lift was right there in the hallway and said she looked down the hall to see if someone was there to assist but did not see anyone. She said she was in the middle of the transfer when the resident started slipping from the lift pad and she called out for help. She said the outgoing nurse, Nurse A, went to Resident #1's room and assisted CNA B in lowering the resident to the ground. She said they proceed to get the resident onto the shower chair and the resident was given her shower. She said the resident did not exhibit any pain. She said Nurse A assessed her at that time and did not see any signs of injury. She said it was not until the following morning, 8/7/24, that CNA B told Nurse B about the incident. She said Nurse B assessed the resident and indicated bruising on the left leg. The Administrator said the family had cameras in the resident's room. She said the family called the DON on 8/7/24 at approximately 4:30 p.m. and the DON assessed the resident on the evening of 8/7/24 and there was bruising on the right shoulder, right lower arm, and left leg. She said an x-ray order was obtained on the 8/7/24 and on 8/8/24. She said the x-ray company still had not come out to the facility and so they obtained an order to send the resident out to the hospital that morning, 08/08/24. She said the resident went to the hospital and at the hospital the x-ray showed an impacted fracture of the proximal humeral metaphysis and that the x-ray of leg was inconclusive, but the CT scan of right lower extremity showed a right periprosthetic fracture of the right distal femur. She said the family decided not do surgery. She said the resident returned to the facility on the 8/12/24. She said on 8/8/24, CNA B was suspended pending the investigation and was terminated at the end the investigation on 8/15/24 because it was concluded that she did not follow appropriate procedure for transferring the resident leading to injury to the resident. She said Nurse A did not follow the proper procedure for documenting and reporting the incident and therefore was issued a final written warning. She said an ANE in-service training was started and completed last week on 8/8/24. She said Nurse A received one on one training about reporting and following through on incidents. She said the potential harm could result in injury. (continued on next page)

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	675777	A. Building B. Wing	09/24/2024

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CNA B's witness statement revealed in part .on the 6th of August, 2024 and between 7 p.m. and 8 p.m.I decided to use the sit and stand Hoyer lift to transfer the patient by myself .I placed the Hoyer lift pad on her back and across her chest .As I was transferring .[Resident #1] started sliding off the lift and I quickly called [Nurse A] .to come and assist me .we then transferred [Resident #1] to the shower chair and I gave her a shower .I did not notice any bruise or any discomfort at that time .I did not report this incident to the night shift nurse because [Nurse A], the day shift nurse is aware and he assessed the resident. Between 9 p.m. and 10 p.m.I observed a bruise on her right leg, and I notified the night shift [Nurse B], and the night shift nurse went and assessed the resident. I have been taking care of this resident even when she was in another hall and when she came to my present hall . During an interview on 08/16/24 at 12:28 p.m., CNA B said it was time to take Resident #1 a shower and she did not get anyone to help her with the transfer because she did not find anyone to help her, and she did not want the resident to fall asleep before she got her showered. She said she used the sit to stand lift. She said they told her she was suspended pending an investigation. Record review of Nurse A's witness statement revealed in part .I assessed residents and no bruise and pain, or discomfort noted. During an interview on 08/16/24 at 11:28 p.m., Nurse A said he was around the nurse's station when CNA B called out for his help. He said when he got to Resident #1's room, her hands were up, and feet were on the floor. He said they lowered the resident to the floor, and he asked CNA B to bring the shower chair. He said they lifted the resident off the floor and put her in the shower chair. He said once the resident was in the shower chair, Nurse A checked the resident's body and did not see any bruises or injuries. Nurse A said he left the room and after that CNA B took the resident a shower. He said he did not do an incident or change in condition report and did not notify the nurse practitioner or doctor because his shift was almost over. He said he did not report it to the oncoming shift nurse because he thought he was just there to help CNA B. He said the resident was a two person assist and said CNA B used a sit to stand lift. He said CNA B did not ask for his help to transfer the resident. He said he received training on completing reports, having the incoming nurse take over, and on Hoyer lifts. He was able to verbalize an understanding of the trainings. During a telephone interview on 08/16/24 at 2:00 p.m., Nurse B said on Wednesday morning, 08/07/24, CNA B told her Resident #1's left leg was bruised. She said she asked CNA B what happened, and CNA B told her last night, 08/06/24, during the transfer for Resident #1's shower, the resident's leg dangled and dropped. Nurse B said she assessed the resident, completed an incident report, called the doctor, notified the DON, and the family. During a follow up interview on 8/29/24 at 4:04 p.m. with CNA B she said she knew Resident #1 was a two-person transfer. She said she had never transferred Resident #1 alone before that day. She said the Hoyer was not working and that was why she used the sit-to-stand lift. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/29/24 at 9:53 a.m. with the Occupational Therapist she stated she had been working at the facility since September 2024 and typically worked from 8 a.m. to 5 p.m. She said Hoyer lifts always required 2 persons to transfer. She said she was familiar with Resident #1 who was a Hoyer lift transfer. She said Resident #1 had paralysis of the right upper and lower side of her body and also had morbid obesity, so she recommended a Hoyer lift be used to transfer. She said she also put it in her assessment notes under the list of precautions section that the resident was a Hoyer lift transfer. She said Resident #1 was unable to bear weight on her legs and could not stand. She said she would not attempt to have Resident #1 stand. She said Resident #1 was not appropriate for a sit to stand lift because she could not stand a little bit and would not even try/initiate to stand. She said one would have to be able to stand a little bit. During an interview on 09/19/24 at 4:30 p.m., the NP said she was notified by telephone about the bruise to Resident #1's lower left leg very early, around 5 a.m., on Wednesday, 08/07/24, by Nurse B. She said Nurse B, did not know anything about a fall at that time. She said she told Nurse B to monitor the bruise and notify the resident's family that a bruise to the lower left leg was found. She said Nurse B went to the resident's room with the telephone, while she was on the line, and the resident did not have any complaints about pain. She said and the resident did not have any history of trauma at that time of the conversation. She said later, 08/07/24, at approximately 1:08 p.m. the family member told her about the bruises, by text message, on the resident's arm and leg. She said resident's family member said he received a call that morning, 08/07/24, from the facility about the bruise on the resident's leg. He said there was also a bruise on her arm above the right elbow that was not mentioned to him. He also mentioned there was an issue with the Hoyer. She said later at one point, by telephone, he mentioned the camera and fall and that he would show her the videos the next day, 08/08/24, but she said she never saw the video because Resident #1 was sent out to the hospital. She said at approximately 9:49 p.m., on 08/07/24, Resident #1's family member sent her pictures of resident's arm and leg. She said she told him that she would see Resident #1 tomorrow, 08/08/24. She said she told him she would put Resident #1 on Tylenol 3 for pain, that she spoke to the DON, Nurse C, and an order for x-rays was placed. She said the x-rays were never done and guessed they were delayed. She said she saw the resident on Thursday, 08/08/24, fed her breakfast, and based on her assessment, she suspected a fracture of her right arm and gave the order to send her out to the hospital. She said the resident did not move her right side normally but believed it would hurt. She said x-rays and CT scans were done in the hospital. She said the resident had a fracture in her arm and knee. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 5:34 p.m., Nurse C said she was not sure what day the incident occurred. She said she noticed Resident #1's bruise the day she returned to work on Wednesday, 08/07/24, day shift, she made her morning rounds. She said CNA E, was in the resident's room and told her that the resident's left leg was swollen. She told CNA E that she had not received a report yet and was going to go get it from Nurse, B. She said after she finished her morning rounds, Nurse B gave her a verbal report and mentioned that the resident hit her left leg last night when she was transferring to the shower. She said at that point she did not know anything about a fall and neither did Nurse B. She said when she took the resident's blood sugar that morning, 08/07/24, the resident did not show any signs or had any complaints of pain. She said at lunch, resident's family member came to her and asked her if she was aware that the resident had a bruise on her arm, and she told him no. She said she told him she knew that Resident #1 hit her leg last night when she was being transferred to the shower. She said she went to the dining room, looked at the resident's arm, noticed a bruise on her arm, and asked CNA E if she noticed the bruise when she got the resident dressed. She said CNA E told her there was not a bruise that morning, 08/07/24. She said when the family member was wheeling the resident out of the dining room and went over the threshold on the floor Resident #1 grimaced, and she could see she was in pain. She said she contacted the NP and informed her about the bruise on her arm and got an order for Tylenol #3. She said she believes she got the x-ray order that Wednesday, 08/07/24, and remembered it being a stat order, but the x-ray vendor never came. The NP gave an order to go ahead and send resident to the hospital on 08/08/24. During an interview on 09/19/24 at 7:19 p.m., the MD said he was informed by the Administrator about Resident #1's fall but could not recall on what day or time. He said the Administrator told him she was going to self-report Resident #1's incident to the State agency. He said someone (did not know who) mentioned the bruise to the NP, the NP mentioned it to him later and said she suspected a fracture and sent the resident out to the hospital. He said at the hospital a fracture was found. He said it would depend what he would have done had he been notified on the day Resident #1 had her fall on 08/06/24. He said initially Resident #1 had no complaints of pain or deformities. He said he could understand the facility waiting until the next day to inform. He said if there were obvious signs of deformities or bone exposure, he would have sent the resident out to the hospital, but if there were no signs of deformities or bone exposure then, there would not necessarily be a need to send the resident out to the hospital on the same day of the fall. He said to his knowledge a bruise was identified next day. He said a bruise alone would not prompt the resident to be sent out to the hospital. He said to his knowledge, the resident was not complaining of pain and not in distress. During a follow-up interview on 9/20/24 at 8:17 a.m., Nurse A said he has been working at the facility since February of 2024. He said since he was still on the clock when Resident #1 fell , it was his responsibility to inform the oncoming nurse about what happened so the nurse could do the follow-up. He said he knows he did not do the right thing. He said it could affect the resident if she was in pain because the pain could get intense, and she could not be feeling well. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/20/24 at 11:12 p.m., the DON said she found out about Resident #1's fall from resident's family member on 08/07/24 by telephone between 5 p.m. and 6 p.m. She said the family told her he did not like the way they cared for Resident #1, and he just looked at the camera and noticed that Resident #1 was on the floor with no clothes on and saw Nurse A and the other nurse (name unknown) in the room. She said she told him she did not know Resident #1 fell and that she was just learning about it from him. She said he was upset, and she told him she was going to find out what happened. She said she called Nurse B and Nurse B said she did not know about the fall and that CNA B only told her about the bruise that happened when she was transferring Resident #1. She said she asked Nurse B if anyone told her Resident #1 fell and she said no one told her. She said she went to the resident's room and assessed her. She said the resident could talk and when she asked her if she was in pain, she said no. She said upon assessment she noticed that her right shoulder, right lower arm, and left leg were bruised. She said when she repositioned her, Resident #1 verbalized pain, and Tylenol was administered. She said on the evening of 08/07/24 at 7:08 p.m. the NP ordered an x-ray and Tylenol #3. She said that night, 08/07/24, she called Nurse A, and he said the x-ray company had not been there yet. She said she called the x-ray company that same night, 08/07/24, and was told they would be there soon. She said on 08/08/24 the NP was at the facility, fed Resident #1 in the morning, and the resident was not in pain. She said the NP made an order to send Resident #1 out to the hospital since the x-ray company had not come yet. During an interview on 09/20/24 at 2:15 p.m., CNA E she said she worked, 08/07/24, from 7 a.m. to 7 p.m. She said CNA B told her Resident #1 had a bruise on her leg but did not recall which leg CNA B told her. She said she told CNA B okay, made her rounds, offered Resident #1 to get out of bed, which she said yes, and got her dressed. She said when she was dressing her, she saw that her leg was swollen but there were no bruises on her body. She said she and Nurse C transferred Resident #1 to her wheelchair using the Hoyer lift. She said she then took the resident to the dining room, passed out trays, and went back on the floor. She said it was either before or after lunch when resident's family member came to her and told her you must be careful with my mom. She said he told her you know she fell . She said she told him she would call Nurse C and he asked her to put his mom back into bed. She said when she was changing Resident #1's blouse to put on her gown, she saw a big bruise on her upper right arm. She said she did not know how it was possible because it was not there that morning. She said resident's family member said you know she fell , and she told him no she did not know. She said she asked him when and he told her last night. She said the resident did not complain of any pain when she dressed her or when she changed her and put her back into bed. She said the resident could not hold a conversation but could say some words and understood what she said. She said she tried to feed her, but she did not eat much, she was not talking, and was not in any pain. In an interview on 09/22/24 at 1:01 p.m., the NP said she did not remember if staff mentioned to her that the resident was experiencing pain or if the notification came from the nurse. She said after the family member notified her about the fall on 08/07/24, she called the DON who said she was already aware. She said she had not been notified by the facility prior to her conversation with the DON. She said she asked the DON to assess the resident (incident report indicated NP notified at 5 p.m.). She said it did not sound like the resident was in bad shape. She said the phone conversation between her, and resident's family member took place approximately between 3-4 p.m. She said the x-ray orders were placed when the DON was in the resident's room conducting the assessment. She said the resident already had an order for Tylenol and was given that in the meantime. She said the resident was on Eliquis and that could have caused a bruise, but she did not know about the fall. She said she did not ask the DON why she was not notified about the fall once the DON learned about the fall. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on 09/23/24 at 6:30 a.m., Nurse B she said CNA B notified her about the bruise on Resident #1's left leg between 6 a.m. and 7 a.m. on 08/07/24 and she went and assessed the resident from head to toe. She said CNA B did not mention a fall and neither did Nurse A. She said she saw a bruise on Resident #1's left leg (middle of her thigh to her shin) and no other bruises on her body. She said she asked the resident about pain and Resident #1 said she did not have any pain. She said she notified the DON, family, and NP. She said the DON said okay. She said the family member said okay and thanked her for letting him know and that they would look at the camera. She said the NP said to go and ask the resident if she was in pain and the resident denied pain. She said later sometime in the afternoon/evening that day, 08/07/24, the DON called her and asked her what really happened, and she told her what she put in her notes is what she was told what happened. She said she was off on the 8th and the 9th. She said on 08/07/24 she gave a verbal report to the oncoming Nurse C between 7 a.m. and when she went home. She said the resident's baseline was a 1 in cognition but was not much verbal. She said Resident #1 would say hello and the resident would slowly say hello back. She said you could get a little information from her, but she did not talk much. She said the resident would repeat what was said to her and could respond slowly with a yes or no. Record review of TULIP revealed the facility made a self-report to the State Agency on 08/08/2024. Record review of the facility's Notification of Changes policy, revised 07/16/24, read in part . 1. the nurse will immediately notify the resident/resident's responsible representative (consistent with his/her authority) and physician for the following changes . an accident involving the resident, which results in injury and has the potential for requiring physician intervention . a significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental or psychosocial status in either life threatening conditions or clinical complication .2. The nurse will notify the resident/resident's representative and the resident's physician for non-immediate change of condition in a timely manner .3. Document the notification . Record review of the facility's Falls policy, revised 07/16/24, read in part . Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force .4. In case of all falls and incidents, notify the family/responsible party and the physician of record .5. The nurse will complete protocols involving falls and incidents . The DON and Administrator were notified on 09/21/24 at 5:45 p.m. and IJ situation was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was accepted on 09/22/24 at 5:31 p.m.: Plan of Removal Date Notified of Immediate Jeopardy: September 21, 2024 Date Removal Plan Developed: September 21, 2024 The facility failed to report Resident #1's change of condition to the MD/NP after she fell on [DATE] when CNA B performed a two person transfer alone. Resident #1 suffered an arm and knee fracture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Place	1321 Park Bayou Dr Houston, TX 77077

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was sent to the hospital for evaluation and returned to the facility with new orders and the plan of care was updated to reflect changes. C.N.A. B's employment was terminated based on the investigation performed by the facility for not following policy and procedure related to Hoyer lift transfers. Nurse A was counseled and received disciplinary action and was provided one on one training on 8/13/24, in regard to completing incident reports and notifying oncoming nurse of incidents in report, as well as notifying family and physician. Resident #1 is stable and has resumed feeding herself with little assistance. Resident #1 remains in the bed per family request and is turned and positioned by staff members. Resident #1 is able to communicate with staff and let basic needs be known. Resident #1 has routine and PRN pain medication for pain management. Resident #1 is at her PLOF, apart from remaining in the bed, which is at the request of the family. Actions to Address System Failure & Date Complete: [NAME] and ADON will develop and in-service nurses and CNAs regarding the following: oImmediate reporting of incidents and change of condition by nurse to NP/MD. oCompletion of incident reports for incidents that occur while nurse is still on the clock. oNurse will notify MD/NP and family member of change of condition. oCNA must report incidents to nurse immediately. oNursing staff will be required to complete training prior to giving direct care to residents. [NAME] BE COMPLETED by 9/22/24 DON and ADON will review incidents and change in conditions from 8/6/24 to current to ensure facility process is followed through to completion. No concerns based on the audit. TO BE COMPLETED BY 9/22/24 DON and ADON to conduct a chart audit from 8/6/24 to current to determine that all changes of condition have been reported to the NP/MD. No concerns based on the audit. COMPLETED 9/22/24 Senior Director of Clinical Services reviewed the incident reporting process in the EMR and system is thorough. At this time no changes to the process are required. COMPLETED 9/22/24 When the NP for the Medical Director was notified of the incident on 8/7/24 at 8am, the Medical Director was informed of the incident. COMPLETED 8/7/24 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A QAPI meeting was held on 8/19/24 and 9/16/24. The incident involving Resident #1 was discussed and Facility Investigative Report was reviewed with no changes made. Facility will continue to review any issues with change of condition processes at monthly QAPI meetings and make recommendations as necessary. COMPLETED 9/22/24 On 09/23/24-09/24/24, surveyor monitoring confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by: 1. Record review revealed in-services were developed and staff were in-serviced regarding the following: o Immediate reporting of incidents and change of condition by nurse to NP/MD. 12 nurses attended the in-service training, dated 09/21/24, and LVN A was in attendance. o Completion of incident reports for incidents that occur while nurse was still on the clock. 12 nurses attended the in-service, dated 09/21/24, and LVN was in attendance, o Nurse will notify MD/NP and family member of change of condition. 12 nurses attended the in-service training, dated 09/21/22, and LVN A was in attendance, o CNA must report incidents to nurse immediately. 18 CNAs attended the in-service training, dated 09/21/24. 2. Record review revealed the DON and ADON completed an audit on incidents and change in conditions from 8/6/24 to current and no concerns were found. 3. Record review revealed the DON and ADON completed a chart audit from 8/6/24 to current to determine that all changes of condition had been reported to the NP/MD. No concerns were found. 4. Record review of LVN A's documentation of his disciplinary action final warning, dated 08/15/24, revealed he was counseled for not completing an incident report when he assisted CAN to lower resident to the floor. He did not call the family, doctor, or report it to the night nurse during report. 5. Record review of the official notification letter, dated, 08/15/24, to CAN B revealed her employment with the facility .was terminated effective Thursday, 08/15/24, due to violation of the [facility's] Professional Behavior in the Workplace Policy . The notification said .Upon conclusion of the investigation, it was substantiated that [CNA B] did violated the policy . 6. Record review of Resident #1's care plan, reviewed 09/10/24, reflected she was at risk for falls, Further review revealed her goals included transfers would be completed by the staff (Hoyer lift) as required, and interventions included Hoyer Lift to transfer. 7. Interview on 09/24/24 at 11:58 a.m. with the Senior Director of Clinical Services revealed the incident reporting process in the electronic medical record (EMR) and system was thorough and no changes to the process were required at this time. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Interview on 09/23/24 at 2:02 p.m. with the MD revealed he was notified by the Administrator and that the NP also mentioned to him Resident #1's incident. 9. Interviews were conducted from 09/23/24 to 09/24/24 with staff from all shifts: Administrator, DON, ADON, 1 RN, 5 LVNs, 9 CNAs, and 2 MAs. Nursing staff verbalized an understanding of who and when to complete incident reports for incidents/change in condition that occurred while a nurse was still on the clock and who to notify in the event of an incident/change in condition. Nurses also verbalized an understanding of who to notify (MD/NP and family). CAN staff verbalized an understanding of who they must report incident to and when. The Administrator was notified the Immediate Jeopardy was re [TRUNCATED]

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on observation, interviews, and records reviewed, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 3 (Resident #1, Resident #2, and Resident #3) of 6 residents reviewed for accidents. -CNA B performed a two person transfer alone using a sit to stand lift instead of a full Hoyer lift when resident was unable to stand on 08/06/24. Resident #1 suffered a right transverse impacted fracture of the proximal humeral metaphysis (broken upper arm) and a right periprosthetic fracture (broken knee bone). -Observation of a Hoyer lift transfer revealed the Hoyer pad/sling was not properly placed under Resident #3's bottom. -CNAs E and F performed a sit to stand transfer for Resident #2 using a cracked footrest and failed to use the calve strap for safety on 08/30/24. On 08/30/24 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/03/24, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of patterned due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk for injuries, pain, hospitalization , and/or death. The findings included: Resident #1 Record review of Resident #1's Face Sheet, dated 08/16/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included aphasia (language disorder that affects speaking or understanding language), hemiplegia (one sided paralysis or weakness caused by brain or spinal cord problems) affecting right dominant side, and muscle wasting and atrophy (loss of muscle leading to shrinking and weakening). Record review of Resident #1's Admission MDS Assessment, dated 05/30/24, revealed a BIMS score of 6, indicating severe cognitive impairment. Further review revealed she was dependent (the assistance of 2 or more helpers was required for the resident to complete the activity) on toileting, showering/bathing, dressing, sit to stand, and chair/bed-to-chair transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's care plan, effective date 05/20/24, revealed the resident had impaired bed mobility, and a communication problem and was rarely understood in ability to express ideas and wants. Further review revealed resident was at risk for falls related to diagnosis of right hemiparesis. Goals included transfers to be completed by staff (transfer boards/lift) as required over the next 90 days and interventions included using the transfer board/lift devices. The care plan did not reflect what type of board/lift device was to be used or how many staff were to assist with the transfer. Observation and attempted interview on 08/30/24 at 8:50 a.m., revealed Resident #1 was lying in bed watching television. Resident said yes when asked if she was fine. Resident said yes, yes when asked if she remembered the incident when she fell , and then her hands and voice started shaking. Interview was ended as not to upset the resident. Observation on 08/16/24 at 9:45 a.m. of several video footage clips, dated 08/06/24, revealed the fall incident began at 19:02:20 p.m. and ended at 19:08:49 p.m. The footage revealed CNA B attempted to use a sit to stand lift (sitting down and standing up from a seat without using your hands for assistance) to transfer Resident #1 from the bed to the shower chair located in the bathroom. During the transfer, Resident #1's arms started sliding up and back from the support vest (helps support upper body) placed around the resident's back and under the arms as CNA B started to move the lift forward and away from the bed. CNA B went towards the bedroom door, returns quickly, stands to the left of the resident, supporting her by her left arm until Nurse A enters the room and helps her lower Resident #1 to the floor. During an interview on 08/16/24 at 10:37 a.m., the Administrator said CNA B disclosed she used the sit to stand lift to transfer Resident #1 when she knew to use the Hoyer lift. She said she transferred the resident on her own when she knew she needed to have another person with her. She said lift transfers required two persons. She said CNA B said she just wanted to hurry and give the resident a shower for the day. She said CNA B said the sit to stand lift was right there in the hallway and said she looked down the hall to see if someone was there to assist but did not see anyone. She said she was in the middle of the transfer when the resident started slipping from the lift pad and she called out for help. She said the outgoing nurse, Nurse A, went to Resident #1's room and assisted CNA B in lowering the resident to the ground. She said they proceed to get the resident onto the shower chair and the resident was given her shower. She said the resident did not exhibit any pain. She said Nurse A assessed her at that time and did not see any signs of injury. She said it was not until the following morning, 8/7/24, that CNA B told Nurse B about the incident. She said Nurse B assessed the resident and indicated bruising on the left leg. The Administrator said the family had cameras in the resident's room. She said the family called the DON on 8/7/24 at approximately 4:30 p.m. and the DON assessed the resident on the evening of 8/7/24 and there was bruising on the right shoulder, right lower arm, and left leg. She said an x-ray order was obtained on the 8/7/24 and on 8/8/24. She said the x-ray company still had not come out to the facility and so they obtained an order to send the resident out to the hospital that morning, 08/08/24. She said the resident went to the hospital and at the hospital the x-ray showed an impacted fracture of the proximal humeral metaphysis and that the x-ray of leg was inconclusive, but the CT scan of right lower extremity showed a right periprosthetic fracture of the right distal femur. CNA B was suspended pending the investigation and was terminated at the end the investigation on 8/15/24 because it was concluded that she did not follow appropriate procedure for transferring the resident leading to injury to the resident. She said she also had the maintenance director look at all the Hoyer lifts to ensure they were all in working order which she said they were. She said he also checked them on a weekly basis (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/16/24 at 11:28 p.m., Nurse A said he was around the nurse's station when CNA B called out for his help. He said when he got to Resident #1's room, her hands were up, and feet were on the floor. He said they lowered the resident to the floor, and he asked CNA B to bring the shower chair. He said they lifted the resident off the floor and put her in the shower chair. He said once the resident was in the shower chair, Nurse A checked the resident's body and did not see any bruises or injuries. He said the resident was a two person assist and said CNA B used a sit to stand lift. He said CNA B did not ask for his help to transfer the resident. During an interview on 08/16/24 at 12:28 p.m., CNA B said it was time to take Resident #1 a shower and she did not get anyone to help her with the transfer because she did not find anyone to help her, and she did not want the resident to fall asleep before she got her showered. She said she used the sit to stand lift. She said she received training on Hoyer lifts. She said they told her she was suspended pending an investigation. During a follow up interview on 8/29/24 at 4:04 p.m. with CNA B she said she knew Resident #1 was a two-person transfer. She said she had never transferred Resident #1 alone before that day. She said the Hoyer was not working and that was why she used the sit-to-stand lift. During an interview on 8/29/24 at 9:53 a.m. with the Occupational Therapist she stated she had been working at the facility since September 2024 and typically worked from 8 a.m. to 5 p.m. She said Hoyer lifts always required 2 persons to transfer. She said she was familiar with Resident #1 who was a Hoyer lift transfer. She said Resident #1 had paralysis of the right upper and lower side of her body and also had morbid obesity, so she recommended a Hoyer lift be used to transfer. She said she also put it in her assessment notes under the list of precautions section that the resident was a Hoyer lift transfer. She said Resident #1 was unable to bear weight on her legs and could not stand. She said she would not attempt to have Resident #1 stand. She said Resident #1 was not appropriate for a sit to stand lift because she could not stand a little bit and would not even try/initiate to stand. She said one would have to be able to stand a little bit. In an interview on 8/30/24 at 9:50 a.m. with CNA B she said the battery was not working, she changed the battery out but still did not work. She said the one in the yellow hall was the one that was not working. She said they trained her on how to use the sit to stand lift and the Hoyer lift. She said she could not remember who trained her. She said she put it on her incident report to let the DON know it was not working. She said she did not remember who the other CNA was that she worked with. During an interview on 8/29/24 at 11:54 a.m. with the ADON she said CNAs have access to the Care Plan Reports. She said they can access a resident's care plan by going into their online computer system, My Unity. She said they also have an ADL cheat sheet located in the shower book that tells them if a resident needs assistance with transfers, what type of assistance, and how many people. During an interview on 8/29/24 at 3:05 p.m., with the MDS Coordinator she said when she gets the information from the staff, she would update the care plan. She said it was mentioned to her that Resident #1 required a Hoyer lift (not certain when it was mentioned). She said the CNAs would know the type of lift required by asking the nurse. She said the CNAs also had access to care plans through their computer system. She said Resident #1 had always been a Hoyer transfer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CNA B's witness statement revealed in part .on the 6th of August, 2024 and between 7 p. m. and 8 p.m.I decided to use the sit and stand Hoyer lift to transfer the patient by myself .I placed the Hoyer lift pad on her back and across her chest .As I was transferring .[Resident #1] started sliding off the lift and I quickly called [Nurse A] .to come and assist me .we then transferred [Resident #1] to the shower chair and I gave her a shower .I did not notice any bruise or any discomfort at that time .I did not report this incident to the night shift nurse because [Nurse A], the day shift nurse is aware and he assessed the resident. Between 9 p.m. and 10 p.m.I observed a bruise on her right leg, and I notified the night shift [Nurse B], and the night shift nurse went and assessed the resident. I have been taking care of this resident even when she was in another hall and when she came to my present hall . Record review of Nurse A's witness statement revealed in part .I assessed residents and no bruise and pain, or discomfort noted. Record review of Nurse A's nursing note entered 08/07/24 at 21:57 p.m. with an effective date of 08/06/24 at 19:20 p.m. revealed he .heard CNA shouting to my name for help around 1900ish, I hurried to her location and found resident's not in cloths hanging on sit to stand both hands in air and legs dropped on the floor. Writer and CNA lowered resident to floor and lifted her with the Hoyer lift mat to the shower chair. As at time writer assessed resident's body there was no any bruise noted. Record review of nursing note dated 08/08/24 at 9:50 a.m., revealed the resident was sent out to the hospital on 08/08/24. Record review of incident/accident report revealed 2 were completed on 08/07/24 for Resident #1. Nurse B completed the first incident report on 08/07/24. The report revealed the resident's leg dropped during transfer with sit to stand lift for shower and resident was noted with bruise to left leg. Resident denied pain and there was no apparent injury at this time. Record review of the 2nd incident/accident report revealed it was completed by the facility's DON on 08/07/24. The report revealed the DON assessed the resident after the son verbalized concern about resident care. Upon assessment the DON observed bruise on right shoulder, right lower arm, and leg. When DON went to reposition resident, resident verbalized pain and pain medication was administered. The NP was notified and said she was going to order x-ray and a pain medication. The type of incident/injury noted was fall while bring assisted. Record review of hospital Facesheet, print date 08/10/24, revealed Resident #1 was sent out to the hospital on 08/08/24. Record review of the Resident #1's hospital discharge paperwork, dated 08/12/24, reflected in part .per orthopedics humerus fracture, nonsurgical, keep in sling. Further review revealed since Resident #1 was immobile and bedbound since her CVA in February there was no benefit of surgical repair of periprosthetic fracture. Resident #1 returned to the facility after discharge on 08/12/24. Resident #2 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's MDS Assessment, dated 7/27/24, revealed BIMS summary score of 7 indicating severe cognitive impairment. His mobility device was a wheelchair and he had partial/moderate assistance from staff for rolling left and right, sit to lying, sit to stand, chair/bed-to-chair transfer, and was dependent on staff for tub/shower transfer and walking 10 feet. Record review of Resident #3's Care Plan effective date 7/30/24 revealed impaired bed mobility with interventions to keep bed in lowest positions as indicated, floor mats as indicated, utilize the following transfer aids was left blank, bed in the lowest position, floor mats. Resident #3 was to be out of bed daily (as tolerated) as required and the intervention was to transfer using the Hoyer lift devices. In an observation of a Hoyer Lift transfer on 9/2/24 at 5:40 pm revealed CNA G preparing to transfer Resident #3 with the Hoyer Lift and Resident #3's family member was observed in the room. Observation of the Hoyer transfer revealed the Hoyer sling was not placed under the resident's bottom so that while he was in the air his bottom was not supported. Observation revealed the Hoyer sling was on Resident #3's back. In an interview on 9/2/24 at 5:57 pm with CNA G she stated usually Resident #3 did not lay straight. She stated the Hoyer pad was supposed to cover the behind. She stated she was not the one who put the sling down and that Resident #3's position was always so hard to get the sling right. CNA G stated if they had someone who laid flat it would be better because they would not be as contracted as Resident #3. In an interview on 9/2/24 at 6:15 pm with Resident #3's family member she stated Resident #3's lower part of the Hoyer sling was not supporting the legs. She stated the facility staff were using the Sit to Stand lift to transfer Resident #3 before and most of the time they transferred Resident #3 with 1 person. She stated her main concern was the safety concern for transferring Resident #3 from what she saw today, 9/2/24. She stated she did not think the green sling was the one they used before and that they used a blue sling. In an interview on 9/5/24 at 10 am with the PT she stated she did the evaluation on the residents to see if they were appropriate for a sit to stand or a Hoyer lift. She stated she started working at the facility in 2016. She stated Resident #3 was on and off therapy when she started working here. She stated he was still able to walk, but he was a Parkinson's patient, and he had a fall. The PT stated now Resident #3 had contractures and had a hard time standing up. She stated when they did the evaluation Resident #3 could barely stand and was able to transfer with 1 to 2 people. She stated they were using a Hoyer lift and then they changed to the Sit to stand Lift because his sitting stance got better. The PT stated something else happened and they did a restorative program to prevent atrophy and the progression of contractures, so they were able to transfer him using the Hoyer lift. She stated the last time she saw Resident #3 was June 2023. The PT stated if the resident cannot control his trunk and cannot stand, they cannot use the Sit to stand lift. She stated they usually tell the staff if the resident cannot help, cannot follow commands, or cannot sit up in the wheelchair then it is automatically a Hoyer lift because they will need 2 to 3 more people. Record review of Facility Sit to Stand lift list, undated revealed Resident #2, Resident #3 were transferred by Sit to Stand lift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Place	1321 Park Bayou Dr Houston, TX 77077

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 9/5/24 at 10:41 am with the DON she stated the therapist assessed all the residents to see whether they were supposed to use a Sit to stand lift or Hoyer lift. The DON stated Resident #3 was using the Sit to stand lift before, but now he was on Hoyer. She stated Resident #2 was transferred by Sit to stand, but now Hoyer. In an interview on 9/5/24 at 10:55 am with the OT she stated she was able to look on the nursing screen to see if they have poor trunk control. She stated the residents who are using a Hoyer lift to transfer do not have trunk control and they need more than 1 person to assist. She stated they screen the residents every quarter for changes in condition. The OT stated Resident #3 was here when he got here. He stated Resident #3 needed help with poor trunk control and that was why he was in the reclining chair, and he cannot stand, he needs more than 1 person, he might grab them, and its best to have 2 people for safety of the Hoyer lift. She started working here a year ago. The OT stated when Resident #3 was admitted to the facility, he should have been on the Hoyer lift for transfers and now he should be on Hoyer. The OT stated Resident #2 was dependent on nursing, but it is appropriate to use the Hoyer lift. In an observation and interview on 8/30/24 at 11:01 a.m. the Director of Rehab demonstrated how to use the sit to stand lift revealed 2 large cracks in the foot stand on the right and left side of the footrest. The Director of Rehab stated the foot strap should be used for safety. She said it would not hold someone who weighed up to the maximum weight. Observation revealed the sit to stand lift was located on the blue hall. In an interview on 8/30/24 at 11:32 a.m. with the DON she said maintenance was checking the sit to stand lift that had cracks on the footrest right now. She said they do quarterly training and spot checking too. She said they did a general training this month and spot checking every day. She said the steps for sit to stand was knock on the resident's door, ask resident if they are in pain, move the chair very close to the bed and first make sure the lift was working. Sit to stand used straps around waist, attach strap to lift hooks, strap in back to hold legs, the bed and lift are close, and you let the resident know and direct resident to put hands on bar. She said partner will be there to assist. Put residents bottom on the bed, lower resident. Procedure was to use leg straps if the resident wants them to be used b/c they cannot force them to use. They have a contract with a local company as a backup. Protocol was for a local company to look at the lifts once a year, but if something is wrong with it, they will look at it sooner. Observation on 08/30/2024from 9:27 a.m. to11:12 a.m. revealed 3 of 3 sit to stand lifts had cracked footrests and none of them had the calve strap used for the safety of the resident. During an interview on 8/29/24 at 4:44 p.m. with the Director of Facilities Management he said the facility has 2 Hoyer lifts 2 sit to stand lifts and to his knowledge none of the Hoyer lifts have been broken he said both Hoyer lifts were new and or obtained in August of 2023. Observation on 8/30/24 at 12:34 pm with the DON revealed 2 Sit to Stand Lifts were cracked on both sides. The DON stated she just had them removed from the floor after the Sit to Stand was found with the crack in it with the Director of Rehab. The DON stated they have ordered 2 more Sit to Stand Lifts. The DON stated she did not know where the calve straps were and that they were normally in the residents' rooms. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 8/30/24 at 12:37 p.m., with the Director of Facilities Management he stated the facility use to have an outside company that came in and did inspections but stopped about a year ago. Inspections are done weekly on all the lifts. He said a quick inspection was done last week. He said he did not notice that the footrest was broken and did not know if it was something he missed. He said the straps should be in storage where the nurses are located. He said he missed one of the lifts and said there was only two sit to stand but there are three. Observation with the Director of facilities management revealed he could not locate where the calve straps were as he looked in their storage area and he stated that he did not remember seeing a calve strap. In an interview on 8/31/24 at 12:08 pm with the DON she stated right now they do not have the sit to stand lifts on the floor in the facility. The DON stated they got rid of the 3rd sit to stand lift because it had a small cut in the plastic. She stated they took all of them off the floor and ordered two new ones. The DON stated they took all the knots out of the Hoyer lift slings and if they could not take the knots out, they cut them off the Hoyer Lift and took them off the floor. The DON stated she asked the staff why they put the knots in the Hoyer lift slings and they said they did not know. She stated they have enough slings, but to be safe they ordered 15 more for the Hoyer Lift. Record review of facility's policy on Mechanical Lift Transfer revised July 16, 2024 revealed, Transfer of a resident between two surfaces will be executed in a manner that protects the wellbeing of the resident . Procedure: The interdisciplinary team to include nursing, the therapy department, and others as identified, will evaluate each resident's transfer status during the admission process to determine appropriate equipment needs for transferring the resident safely. During the evaluation process, specific transfer needs will be identified including type of equipment needed and number of staff needed for transferring the resident. On 8/30/24 at 3:03 p.m., the DON and Administrator were notified of the Immediate Jeopardy due to the above failures. The IJ template was left with the DON and a plan of removal was requested at that time. In an interview on 8/31/24 at 12:12 pm with the DON she stated the facility had an IJ because a CNA used the wrong Lift for Resident #1 and in the process the resident sustained a major injury. She stated CNA B used the wrong equipment and she did not follow the protocol by asking someone to help her while using the equipment and in the process the resident sustained an injury. In an interview on 9/1/24 at 12:20 pm with Administrator B she stated they had 3 sit to stand lifts and all 3 sit to stand lifts needed to be taken out because the foot stand had cracks in them. She stated they ordered the 2 new sit to stand lifts and they will arrive on Friday, 9/6/24. She stated the first sit to stand lift will not come until Wednesday, 9/4/24. She stated the facility had an IJ because they had mechanical sit to stands on the floor that were not in working order. She stated they must make sure the employees are not using any lifts by themselves. The following Plan of Removal (POR) was submitted by the facility and accepted on 8/31/24 at 10:14 a.m.: Plan of Removal Date Notified of Immediate Jeopardy: August 30, 2024 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Date Removal Plan Developed: August 30, 2024 The facility failed to safely transfer Resident #1 when CNA B performed a two person transfer alone using a sit to stand lift instead of a full Hoyer lift when resident was unable to stand on 08/06/24. Resident #1 suffered an impacted transverse fracture of the proximal humeral metaphysis, right distal femur periprosthetic fracture with valgus deformity - non weight baring, and a left proximal humerus fracture, transverse. The facility failed to ensure Hoyer lifts were maintained and of good working condition. Resident #1 was sent to the hospital for evaluation and returned to the facility with new orders and the plan of care was updated to reflect changes. C.N.A. B's employment was terminated based on the investigation performed by the facility for not following policy and procedure related to Hoyer lift transfers. Actions to Address System Failure & Date Complete: DON and ADON will develop and in-service staff regarding the following: o The appropriate lift to be used on each resident. o The procedure on how to use a sit-to-stand lift and a Hoyer lift. The DON and ADON will read the instructions for use when new stands arrive and will In-Service the staff based upon these instructions. New lifts are pending delivery date at this time. o The number of staff required to use any lift. o Using the correct pad during lift transfers and any calf straps that are required for the sit-to-stand lifts. o Inspect the lifts and pads before use to ensure that they are in good condition. o What to do if a lift or pad is found to not be in good condition. TO BE COMPLETED by 9/1/24 Central Supply Director inspected all pads and removed any knots in the slings and inspected all for wear and tear. All not found to be in good condition were thrown away. COMPLETED 8/30/24 The two sit to stand lifts that were found to not be in good working order were removed from the floor immediately and discarded. COMPLETED 8/30/24 The Maintenance Director created a TELS work order and inspected all current Hoyer lifts in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	COMPLETED 8/30/24 The Maintenance Director placed an order for two new sit to stand lifts for the facility. COMPLETED 8/30/24 The Maintenance Director has ordered the lifts and at this time is awaiting a delivery date confirmation. The Maintenance Director placed an order for 25 additional slings (in various sizes) to have on hand at the facility when needed. COMPLETED 8/30/24 All residents that used a sit to stand lift today were assessed by their nurse for any adverse effect or injury. COMPLETED 8/30/24 Therapy evaluated the 4 current residents using a sit-to-stand lift and recommended that they could use a Hoyer lift until the new sit to stands arrive. All residents, responsible parties and MD were notified. The MD for all residents affected was the Medical Director. COMPLETED 8/30/24 All Care Plans for these current residents were updated to reflect the change in lift to be used. COMPLETED 8/30/24 The facility is currently evaluating the current policy/procedure for transfers and or lift use and revising as necessary in consultation with the Medical Director TO BE COMPLETED 9/1/24 The facility is currently evaluating the root-cause of the system break down related to the lifts not being in working order and putting a system in place for future evaluation of lifts. TO BE COMPLETED 9/1/24 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Facility Competency Procedure Lifting Machine, Using a Mechanical Lift dated 8/31/24 revealed, The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. General Guidelines: At least 2 nursing assistants are needed to safely move a resident with a mechanical lifting device. Mechanical lifts may be used for tasks that require: Lifting a resident from the floor, transferring a resident from the bed to the chair, lateral transfers, lifting limbs .Types of lifts in the facility: Floor based full body lifts, and Sit to Stand Lifts .Before using a lifting device, assess the resident's current condition, including: Physical-Can the resident assist with transfer? Is the resident's weight and medical condition appropriate for the use of a lift? Cognitive/Emotional- Can the resident understand and follow instructions .Make sure that the battery is charged. Test the lift controls. Ensure that the emergency release feature works. Make sure the lift is stable and locked. Make sure that all necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition .Place the sling under the resident . On (date- date) surveyor monitoring confirmed the facility implemented their plan or removal (POR) to sufficiently remove the IJ by 1. Record review revealed in-services were developed and staff were in-serviced regarding the fo [TRUNCATED]

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45328 Based on interviews, observations, and records reviewed, the facility failed to obtain radiology or other diagnostic services to meet the needs of its residents in a timely manner for 1 (Resident #1) of 7 residents reviewed for radiology services. -The facility failed to obtain radiology services for Resident #1 in a timely manner after she fell on [DATE] and bruises appeared on 08/07/24. Resident #1 suffered a right transverse impacted fracture of the proximal humeral metaphysis (broken upper arm) and a right periprosthetic fracture (broken knee bone). On 09/21/24 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 09/24/24, the facility remained out of compliance at a severity level of no actual harm with potential for minimal harm and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place resident at risk of results in delayed diagnosis, medical treatment, and hospitalization . The findings included: Record review of Resident #1's Face Sheet, dated 08/16/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included aphasia (language disorder that affects speaking or understanding language), hemiplegia (one sided paralysis or weakness caused by brain or spinal cord problems) affecting right dominant side, and muscle wasting and atrophy (loss of muscle leading to shrinking and weakening). Record review of Resident #1's Admission MDS Assessment, dated 05/30/24, revealed a BIMS score of 6, indicating severe cognitive impairment. Further review revealed she was dependent on toileting, showering/bathing, dressing, sit-to stand, and chair/bed-to-chair transfer. Record review of Resident #1's care plan, effective date 05/20/24, revealed the resident had impaired bed mobility, may not be able to adequately verbalize pain related to diagnosis of aphasia following cerebral infarction, and a communication problem and was rarely understood in ability to express ideas and wants. Further review revealed resident was at risk for falls related to diagnosis of right hemiparesis. Goals included transfers to be completed by staff (transfer boards/lift) as required over the next 90 days and interventions included using the transfer board/lift devices. The care plan did not reflect what type of board/lift device was to be used or how many staff were to assist with the transfer. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 08/16/24 at 9:45 a.m. of several video footage clips, dated 08/06/24, revealed the fall incident began at 19:02:20 p.m. and ended at 19:08:49 p.m. The footage revealed CNA B attempted to use a sit to stand lift (sitting down and standing up from a seat without using your hands for assistance) to transfer Resident #1 from the bed to the shower chair located in the bathroom. During the transfer, Resident #1's arms started sliding up and back from the support vest (helps support upper body) placed around the resident's back and under the arms as CNA B started to move the lift forward and away from the bed. CNA B called out for help and Nurse A entered the room and helped lowered Resident #1 to the floor. Observation and attempted interview on 08/30/24 at 8:50 a.m., revealed Resident #1 was lying in bed watching television. Resident said yes when asked if she was fine. Resident said yes, yes when asked if she remembered the incident when she fell , and then her hands and voice started shaking. Interview was ended as not to upset the resident. During a telephone interview on 08/16/24 at 2:00 p.m., Nurse B said on Wednesday morning, 08/07/24, CNA B told her Resident #1's left leg was bruised. She said she asked CNA B what happened, and CNA B told her last night, 08/06/24, during the transfer for Resident #1's shower, the resident's leg dangled and dropped. Nurse B said she assessed the resident, completed an incident report, called the doctor, notified the DON, and the family. During an interview on 09/19/24 at 4:30 p.m., the NP said she was notified by telephone about the bruise to Resident #1's lower left leg very early, around 5 a.m., on Wednesday, 08/07/24, by Nurse B. She said Nurse B, did not know anything about a fall at that time. She said she told Nurse B to monitor the bruise and notify the resident's family that a bruise to the lower left leg was found. She said Nurse B went to the resident's room with the telephone, while she was on the line, and the resident did not have any complaints about pain. She said and the resident did not have any history of trauma at that time of the conversation. She said later, 08/07/24, at approximately 1:08 p.m. the family member told her about the bruises, by text message, on the resident's arm and leg. She said resident's family member said he received a call that morning, 08/07/24, from the facility about the bruise on the resident's leg. He said there was also a bruise on her arm above the right elbow that was not mentioned to him. He also mentioned there was an issue with the Hoyer. She said later at one point, by telephone, he mentioned the camera and fall and that he would show her the videos the next day, 08/08/24, but she said she never saw the video because Resident #1 was sent out to the hospital. She said at approximately 9:49 p.m., on 08/07/24, Resident #1's family member sent her pictures of resident's arm and leg and said he was concerned that the bruise could lead to blood clot formation. She said she told him that she would see Resident #1 tomorrow, 08/08/24, and the chances of a deep vein thrombosis was almost impossible. She said she let him know that it could cause a hematoma, bruises would look worse before they looked better, and bruises should resolve in 1-2 weeks. She said she told him she would put Resident #1 on Tylenol 3 for pain, that she spoke to the DON, Nurse C, and an order for x-rays was placed. She said the x-rays were never done and guessed they were delayed because of the vendor but was not sure of the reason. She said from experience the vendor could have staffing issues. She said she saw the resident on Thursday, 08/08/24, fed her breakfast, and based on her assessment, she suspected a fracture of her right arm and gave the order to send her out to the hospital. She said the resident did not move her right side normally but believed it would hurt. She said x-rays and CT scans were done in the hospital. She said the resident had a fracture in her arm and knee. She said surgical intervention was not needed. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/19/24 at 5:34 p.m., Nurse C said CNA E, was in the resident's room and told her that the resident's left leg was swollen. She told CNA E that she had not received a report yet and was going to go get it from Nurse, B. She said after she finished her morning rounds, Nurse B gave her a verbal report and mentioned that the resident hit her left leg last night when she was transferring to the shower. She said at that point she did not know anything about a fall and neither did Nurse B. She said when she took the resident's blood sugar that morning, 08/07/24, the resident did not show any signs or had any complaints of pain. She said at lunch, resident's family member came to her and asked her if she was aware that the resident had a bruise on her arm, and she told him no. She said she told him she knew that Resident #1 hit her leg last night when she was being transferred to the shower. She said she went to the dining room, looked at the resident's arm, noticed a bruise on her arm, and asked CNA E if she noticed the bruise when she got the resident dressed. She said CNA E told her there was not a bruise that morning, 08/07/24. She said when the family member was wheeling the resident out of the dining room and went over the threshold on the floor Resident #1 grimaced, and she could see she was in pain. She said she contacted the NP and informed her about the bruise on her arm and got an order for Tylenol #3. She said she believes she got the x-ray order that Wednesday, 08/07/24, and remembered it being a stat order, but the x-ray vendor never came. She said she asked night Nurse A on Thursday, 08/08/24, morning if the x-ray company had been out, and he said no. She said she called the x-ray company Thursday, 08/08/24, morning and was told they were going to send someone out, but the NP gave an order to go ahead and send resident to the hospital on 08/08/24. She said she did not recall exactly what the x-ray vendor said as to why they had not come out to complete the x-rays on 08/07/04 but said she recalled them just saying they could not get to the resident on 08/07/24. She said she gave Resident #1 Tylenol #3. She said the resident was sent out to the hospital the following day, 08/08/24. During an interview on 09/19/24 at 7:19 p.m. the MD said he was informed by the Administrator about the resident's fall but could not recall on what day or time. He said the Administrator told him she was going to self-report Resident #1's incident to the State Agency. He said someone (unknown) mentioned the bruise to the NP and the NP mentioned it to him later and said she suspected a fracture and sent the resident out to the hospital. He said at the hospital a fracture was found. He said it would depend what he would have done had he been notified on the day Resident #1 had her fall on 08/06/24. He said initially the resident had no complaints of pain or deformities. He said he could understand the facility waiting until the next day to inform. He said if there were obvious signs of deformities or bone exposure, he would have sent the resident out to the hospital, but if there were no signs of deformities or bone exposure then, there would not necessarily be a need to send the resident out to the hospital on the same day of the fall. He said to his knowledge a bruise was identified next day. He said a bruise alone would not prompt the resident to be sent out to the hospital. He said to his knowledge, the resident was not complaining of pain and not in distress. During a telephone interview on 09/20/24 at 9:24 a.m., a representative with the radiology company said a normal priority order was placed on 8/7/24 and cancelled on 8/8/24. He said Nurse C called in the order on 08/07/24 and scheduled it for 08/08/24. (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/20/24 at 10:16 a.m., the ADON said she heard about the x-ray orders during the morning meeting on 08/08/24 and that they were waiting for the x-rays to be done. She said she did not know if the x-ray order was a stat order. She said she did not know why there was a delay with the x-ray order. She said the night shift nurse (name unknown) called and checked about the order and then called again on 08/08/24. She said she did not recall if the nurse said what the x-ray company said. She said on 08/08/24 the x-ray company showed up, but the resident was on the way out to the hospital. She said none of the staff ever mentioned that the resident was experiencing any pain. She said if it was a stat order, the x-ray company should have come between 4 to 6 hours. She said if it was a normal x-ray order it would determine when the vendor would come out. If it was called in in the morning, they would come that day. If it was called past 4 p.m. then most likely if would be the following day. She said the affect is that you don't know what is wrong with the resident because the x-ray is supposed to confirm something such as if there is a fracture or not. She said in the meantime, you would just treat the symptoms you see and make the resident comfortable as much as you can. During an interview on 09/20/24 at 10:46 a.m., the NP said the x-ray order would have been a stat order because the Resident #1 had a bruise. She said had she been notified of the fall on 08/06/24 it would depend on the assessment that would determine what the next plan would be. She said if there was pain, there would have been x-rays and if she hit her head she would be sent out to the hospital. She said every fall was not the same. She said the family member told her it was a fall on 08/07/24 and when she called the facility, she spoke with the DON and was told that they already knew. During an interview on 09/20/24 at 11:12 p.m., the DON said she found out about Resident #1's fall from resident's family member on 08/07/24 by telephone between 5 p.m. and 6 p.m. She said the family told her he did not like the way they cared for Resident #1, and he just looked at the camera and noticed that Resident #1 was on the floor with no clothes on and saw Nurse A and the other nurse (name unknown) in the room. She said she told him she did not know Resident #1 fell and that she was just learning about it from him. She said he was upset, and she told him she was going to find out what happened. She said she called Nurse B and Nurse B said she did not know about the fall and that CNA B only told her about the bruise that happened when she was transferring Resident #1. She said she asked Nurse B if anyone told her Resident #1 fell and she said no one told her. She said she went to the resident's room and assessed her. She said the resident could talk and when she asked her if she was in pain, she said no. She said upon assessment she noticed that her right shoulder, right lower arm, and left leg were bruised. She said when she repositioned her, Resident #1 verbalized pain, and Tylenol was administered. She said on the evening of 08/07/24 at 7:08 p.m. the NP ordered an x-ray and Tylenol #3. She said that night, 08/07/24, she called Nurse A, and he said the x-ray company had not been there yet. She said she called the x-ray company that same night, 08/07/24, and was told they would be there soon. She said on 08/08/24 the NP was at the facility, fed Resident #1 in the morning, and the resident was not in pain. She said the NP made an order to send Resident #1 out to the hospital since the x-ray company had not come yet. She said the x-ray company arrived on 08/08/24 but did not complete the x-rays as resident was already leaving to the hospital. She said she does not think the x-ray order was a stat order. She said a stat order takes about 4-6 hours and a regular order at maximum can take the next day. She said she did not know why there was a delay. She said when they found out there was a delay, they sent Resident #1 to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Place	1321 Park Bayou Dr Houston, TX 77077

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on 09/23/24 at 6:30 a.m., Nurse B said CNA B did not mention a fall and neither did Nurse A. She said she saw a bruise on left leg (middle of her thigh to her shin) and no other bruises on her body. She said she asked Resident #1 about pain, and she said she said she did not have any pain. During an interview on 09/23/24 at 2:02 p.m. the MD said usually an x-ray order was stat when you have an obvious deformity or severe pain, but it all depends on the patient and their circumstances. He said it also depends on the goals of care such as comfort or quality of life (palliative care). He said his understanding was the resident was more palliative care. He said most important is the deformity that one could see in the clinical exam and the symptoms of the patient that will decide if order is stat or routine. He said based on the information that he received from the NP and the DON it was acceptable to get a routine x-ray. He said the NP told him Resident #1 was having some pain and it could have been with some of the movement because she was paralyzed. During an interview on 09/23/24 at 2:24 p.m., Nurse C said she placed the x-ray order on 08/07/24 in the evening before her shift ended. She said she received the order via text from the NP, and it did not specify if it was a stat or routine order which meant it would have had to be routine if it did not say stat. She said a stat order had to say stat or she could have texted her back and asked if it was stat or routine to clarify but normally, the NP would have said stat. She said she did not clarify with the NP if it was stat or routine order. She said all stat x-ray orders said stat. Record review of CNA B's witness statement revealed in part .on the 6th of August, 2024 and between 7 p. m. and 8 p.m.I decided to use the sit and stand Hoyer lift to transfer the patient by myself .I placed the Hoyer lift pad on her back and across her chest .As I was transferring .[Resident #1] started sliding off the lift and I quickly called [Nurse A] .to come and assist me .we then transferred [Resident #1] to the shower chair and I gave her a shower .I did not notice any bruise or any discomfort at that time .I did not report this incident to the night shift nurse because [Nurse A], the day shift nurse is aware and he assessed the resident. Between 9 p.m. and 10 p.m.I observed a bruise on her right leg, and I notified the night shift [Nurse B], and the night shift nurse went and assessed the resident. I have been taking care of this resident even when she was in another hall and when she came to my present hall . Record review of Nurse A's witness statement revealed in part .I assessed residents and no bruise and pain, or discomfort noted. Record review of Nurse A's nursing note entered 08/07/24 at 21:57 p.m. with an effective date of 08/06/24 at 19:20 p.m. revealed he .heard CNA shouting to my name for help around 1900ish, I hurried to her location and found resident's not in cloths hanging on sit to stand both hands in air and legs dropped on the floor. Writer and CNA lowered resident to floor and lifted her with the Hoyer lift mat to the shower chair. As at time writer assessed resident's body there was no [sic] any bruise noted. Record review of nursing note dated 08/08/24 at 9:50 a.m., revealed the resident was sent out to the hospital on 08/08/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675777	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Parkway Place		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Park Bayou Dr Houston, TX 77077	

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of incident/accident report revealed 2 were completed on 08/07/24 for Resident #1. Nurse B completed the first incident report on 08/07/24. The report revealed the resident's leg dropped during transfer with sit to stand lift for shower and resident was noted with bruise to left leg. Resident denied pain and there was no apparent injury at this time. Record review of the 2nd incident/accident report revealed it was completed by the facility's DON on 08/07/24. The report revealed the DON assessed the resident after the son verbalized concern about resident care. Upon assessment the DON observed bruise on right shoulder, right lower arm, and leg. When DON went to reposition resident, resident verbalized pain and pain medication was administered. The NP was notified and said she was going to order x-ray and a pain medication. The type of incident/injury noted was fall while bring assisted. Record review of the Resident #1's hospital discharge paperwork, dated 08/12/24, revealed .Details of stay as per assessment plan are as follows: 1. Humerus fracture (S42.309A) Reviewed CT: Acute comminuted right humerus surgical neck fracture (break of the humerus bone in the upper arm). Orthopedic surgery was consulted from ED: non operative management for now and sling .12. Right knee pain (M25.561) CT confirms periprosthetic fracture and recommend ortho evaluation. Discussed with [Dr.] , since patient is bedbound since her CVA, does not walk or transfer, per [family member] has been using a Hoyer lift at facility does not need surgery . Resident #1 returned to the facility after discharge on 08/12/24. The DON and Administrator were notified on 09/21/24 at 5:45 p.m. an IJ situation was identified due to the above failures and the IJ template was provided. The following Plan of Removal (POR) was submitted by the facility and accepted on 9/22/24 at 5:31 p.m.: Plan of Removal Date Notified of Immediate Jeopardy: September 21, 2024 Date Removal Plan Developed: September 21, 2024 The facility failed to obtain radiology services for Resident #1 in a timely manner after she fell on [DATE] and bruise appeared on 8/7/24. Resident #1 suffered an arm and knee fracture from the fall. Resident #1 is stable and has resumed feeding herself with little assistance. Resident #1 remains in the bed per family request and is turned and positioned by staff members. Resident #1 is able to communicate with staff and let basic needs be known. Resident #1 has routine and PRN pain medication for pain management. Resident #1 is at her PLOF, apart from remaining in the bed, which is at the request of the family. Actions to Address System Failure & Date Complete: DON and ADON will develop and in-service nurses regarding the following: (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	oObtaining radiology orders from NP/MD following an incident or resident change in condition when there is concern for injury. oWhen Stat order is received, following up with NP/MD if radiology has not been completed within four hours to obtain order to send to ER if applicable. oNurses will need to complete training prior to direct care with residents. TO BE COMPLETED by 9/22/24 DON and/or designee will review incidents and change in conditions daily to ensure that radiology orders are obtained and followed through to completion. TO BE COMPLETED BY 9/22/24 DON and ADON will audit current radiology orders and orders back to 8/6/24 to ensure that they are completed in a timely manner. After review of orders, there were no delays in radiology services at this time. COMPLETED 9/22/24 When the NP for the Medical Director was notified of the incident on 8/7/24 at 8am, the Medical Director was informed of the incident. COMPLETED 8/7/24 A QAPI meeting was held on 8/19/24 and 9/16/24 there were no issues with radiology services identified at either time. Facility will continue to review radiology services at monthly QAPI meetings and make recommendations as necessary. COMPLETED 9/22/24 Radiology Services process was reviewed and no changes are needed. Facility to obtain radiology services per the NP/MD orders. If STAT services are ordered, expectation is within four hours. If radiology services are not fulfilled within the 4 hours, nurse is to reach out to NP/MD to obtain order to send resident to hospital if applicable. COMPLETED 9/22/24 On 09/23/24-09/24/24 the surveyor monitoring confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: 1. Record review revealed in-services were developed and nurses were in-serviced regarding the following: o Obtaining radiology orders from NP/MD following an incident or resident change in condition when there (continued on next page)

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F 0776 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	is concern for injury. 12 nurses attended the in-service on 09/21/2024, and LVN A was in attendance. o When Stat order is received, following up with NP/MD if radiology has not been completed within four hours to obtain order to send to ER if applicable. 12 nurses attended the in-service on 09/21/2024, and LVN A was in attendance. 2. Record review revealed the DON and ADON completed reviews of incidents and change in conditions to ensure radiology orders were obtained and followed through completion. 3. Record review revealed the DON and ADON audited radiology orders back from 08/06/24 to ensure they were completed timely and found no delays. 4. Interview with the NP revealed she was notified about Resident #1's incident on 08/07/24. 5. Interviews were conducted from 09/23/24 to 09/24/24 with nurses from all shifts: DON, ADON, 1 RN, and LVNs. Nursing staff verbalized an understanding of when to obtain radiology orders from the MD/NP following an incident or resident change in condition when there is a concern for injury, when to follow up on a stat order and the timeframe of when a stat order should be completed, and what to do if there is a delay with a radiology. The Administrator was notified the Immediate Jeopardy was removed on 09/24/2024 at 12:06 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.