| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/14/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marine Creek Nursing and Rehabilitation | 3600 Angle Ave<br>Fort Worth, TX 76106 |

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) |
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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on observation, interview, and record review the facility failed to ensure residents in the facility were free from neglect for 1 (Resident #1) of 6 residents reviewed for neglect.<br><br>Student Nurse Aide A, who worked the 2:00 PM-10:00 PM shift, failed to report to the charge nurse when she found Resident #1 on the floor on 04/09/24 at 9:46 PM resulting in the resident not receiving immediate treatment and care until 4:40 AM on 04/10/24, when 10:00 PM-6:00 AM staff, discovered significant bruising and injury to the resident's face/head. This failure resulted in the resident not being assessed by a nurse, not having neurological checks performed, not receiving monitoring for possible serious injury, and the physician not being notified for approximately six hours after the fall when the resident was discovered to have significant bruising and injury to the right side of her face and head. The facility failed to ensure Student Nurse Aide A knew what to do when a resident was found on floor.<br><br>An Immediate Jeopardy was identified on 04/13/24 at 7:20 PM. While the Immediate Jeopardy was removed on 04/14/24 at 2:15 PM, the facility remained out of compliance at a scope of isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's continuation of in-servicing and monitoring the plan of removal.<br><br>These failures could place residents at risk for serious injury, hospitalization and/or death.<br><br>Findings included:<br><br>Record review of Resident #1's face sheet, dated 04/14/24, revealed the resident was an [AGE] year-old female, who was admitted to the facility 09/08/23. Resident #1 had diagnoses which included dementia with other behavioral disturbance (impaired ability to remember, think, or make decisions), Type 2 diabetes, repeated falls, lack of coordination, unsteadiness on feet, essential hypertension (high blood pressure) and muscle weakness.<br><br>Record review of Resident #1's MDS quarterly assessment dated [DATE], revealed her BIMS score was not completed due to resident being rarely/never understood. MDS further revealed Section E - Behaviors for Wandering occurred daily. Resident #1 was able to ambulate without any mobility devices.<br><br>(continued on next page) |

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

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

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's Care plan revised dated 04/12/24, revealed Focus: The resident had an actual fall r/t poor safety awareness, impulsive, impaired mobility. Goal: The resident will not sustain serious injury through review date. Interventions: Bed in lowest position. Anticipate and meet the resident's needs. Assist resident back to bed during night shift when she is ambulating and lethargic. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Bolster mattress cover to bed. Continue frequent redirection with resident in an attempt to reduce falls. Encourage resident to sit throughout the day to prevent lethargy. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. fall mat at bedside. Frequent visualization throughout the night to ensure resident safety and redirect as needed. Soft helmet when out of bed as resident tolerates to prevent head injury - refuses to wear.<br><br>Review of Resident #1's progress note documented by Physician dated 04/10/24 at 4:40 AM reflected:<br><br>Fall - Head injury. Plan: [AGE] year-old admitted to [Facility] on 9/8/2023 for rehabilitation and/or long-term care secondary to dementia. The patient has a medical history significant for dementia, diabetes mellitus, generalized anxiety, vitamin B12 deficiency hyperlipidemia and hypertension.<br><br>Plan:<br><br>1. Neuro checks as per protocol<br><br>2. Skulls Series<br><br>3. Contact DON/ADON to schedule care plan and root cause evaluation to establish what interventions are needed.<br><br>4. Hold anticoagulants, Plavix, Eliquis, Xarelto for three days if head injury visualized or suspected.<br><br>5. Consider need to send for labs if hypotensive, tachycardic or has altered mental status/increased impulsivity.<br><br>6. Order xray for relevant bony structures if patient has point tenderness/swelling on exam.<br><br>7. Tylenol 1000 mg po q8h prn pain for 72 hours.<br><br>Review of Resident #1's Event Nurses Note - Bruise dated 04/10/24 at 5:41 AM, revealed the following: Location event occurred - Unknown. Location of Injury: Right side of the forehead. Description: Blue/Purple, Unknown Origin. Nursing description of the event: [CNA reported that had a big purple bruise on the right side of the forehead].<br><br>Review of Resident #1's progress note documented by LVN B at 04/10/24 at 5:57 AM revealed the following: Cna reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Event Nurses Note - Fall dated 04/10/24 at 6:01 AM revealed the following: Location event occurred - Unknown. Unwitnessed, Hit Head. Injury - Bruise. Right side of forehead. Swelling Present, Blue/Purple. CNA reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>Review of Resident #1's Final X-Ray Report dated 04/10/24 at 15:14 [3:14 PM] revealed the following:<br><br>Examination: PELVIS, RIGHT SHOULDER, SKULL. Clinical Indication: Pain in right shoulder; pelvic and perineal pain; unspecified fall, initial encounter.<br><br>SKULL - Findings: There is no definite displaced or depressed calvarial fracture by plain film. Impression: No definite acute displaced or depressed calvarial fracture by plain film.<br><br>RIGHT SHOULDER - Findings: There is an old healed fracture of the proximal diaphysis of the right humerus. No acute fracture or dislocation is identified. Impression: No acute fracture is identified.<br><br>PELVIS - Findings: No acute fracture or dislocation. Impression: No acute osseous abnormality is seen.<br><br>Review of facility's Incident Report completed by the DON, dated 04/12/24 reflected the following: Date of Incident: 04/10/24 5:47AM - CNA reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified. Conclusion: Resident observed on the floor by aide beside her bed. Large purple bruise noted to right side of forehead and eye as a delayed injury to fall. Interventions: Frequent visualization during evening and night hours as resident becomes restless. Psych to continue to evaluate and adjust meds as indicated. Resident refuses to allow helmet to be placed on her. Continue low bed and fall mat at bedside.<br><br>Observation on 04/13/24 at 9:44 AM revealed Resident #1 in her room sleeping in B Bed with floor mats on each side of her bed. Resident #1 was covered up to her forehead. A swollen dark purple/blue bump was observed on the right side of the resident's forehead/temple.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and interview on 04/13/24 at 11:10 AM revealed Resident #1 in her room sitting on a chair. Resident #1 had significant bruising to her right side of her face. The bruise started from Resident #1's forehead, spread all the way down to her neck and both of her eyes were bruised. Resident #1 was not a good historian, and she was unable to recall having a fall. She denied being in any pain. Interview with Resident #1's Family Member revealed Resident #1 had a fall the night of 04/09/24 at 7:55 PM. She stated Resident #1 was on the floor until 4:33 AM. Resident #1's Family Member stated she had a camera in the resident's room. She stated the camera recorded footage when motion was detected and only recorded in 6 seconds increments. Review of camera footage date stamped 04/09/24 at 19:40 [7:40 PM] revealed Resident #1 was lying in bed trying to get up, and her bed was in a low position with no fall mats observed. Resident #1's bedside table, walker, and a chair on the right side of resident bed closed by. At 19:55 [7:55 PM] Resident #1 was on the floor lying on her right side. Camera footage did not show how the resident fell or if she hit herself and no sounds were made by the resident. Resident #1 was observed moving her head and left arm. At 21:46 [9:46 PM] it was observed a staff member with pink scrubs entered the room and left. The camera footage audio revealed the staff voicing while she was leaving the room at 21:46 [9:46 PM] Hey can you get the aide. At 21:58 [9:58 PM] Resident #1 was observed in bed. The camera footage did not show who or how Resident #1 was placed back in bed. Resident #1 was positioned horizontally on her right side with her feet hanging from the bed. There was no movement in the room for the camera to record from 21:58 [9:58 PM] to 4:17 AM Resident #1 was lying in bed vertical position. No observation of fall mat. At 4:33 AM a CNA was observed prepping to provide incontinence care for Resident #1, and Resident #1 was observed turning to her left side. Resident #1's Family Member stated she had a missed call from the facility on 04/10/24 at 4:59 AM and then within seconds she returned the call. She stated the facility nurse contacted her and notified her of the bruise. She stated the nurse asked her to review the cameras because they were not sure how Resident #1 sustained the bruise. She stated she reviewed the camera footage and noticed Resident #1 had the fall. Resident #1's Family Member stated she could not recall the name of the nurse who called her. She stated she had not been told much about the incident only that they had completed x-rays and results were fine.<br><br>Interview on 04/13/24 at 12:04 PM with LVN A revealed he was the charge nurse assigned to the secure unit. He stated Resident #1 bruise was noted the morning of 04/10/24 by the 10PM-6AM staff. He stated he believed Resident #1 had a fall the night of 04/09/24 unsure how; however, Resident #1 sustained a bruise to her right side of her forehead. He stated throughout the days the bruise began to spread all over Resident #1's right side of the face. LVN A stated Resident #1 was able to ambulate on her own. He stated they provided Resident #1 with a wheelchair or a walker but Resident #1 refused to use them. LVN A stated they completed an x-ray on 04/10/24 with no findings.<br><br>Interview on 04/13/24 at 12:19 PM with CNA B revealed she was the assigned CNA for Resident #1. She stated the morning of 04/10/24 she came in for her shift at around 5:45 AM, she stated she was given report that Resident #1 had a bruise to her forehead, she stated resident had a fall during the 2:00 PM-10:00 PM shift and someone had picked her up. She stated she was not provided with much information. She stated when she completed her rounds the morning of 04/10/24, she was not able to see the bruise due to Resident #1 sleeping on her right side. She stated she could not recall the CNA who noticed the bruise.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/13/24 at 12:59 PM with LVN C revealed she was the nurse assigned to the secure unit on 04/09/24 from 2:00 PM-10:00 PM shift. She stated during her shift, her CNAs were CNA H for the male side and another CNA for the female side but could not recall her name. LVN C stated her shift ended at around 11:30 PM. She stated the last time she observed Resident #1 on 04/09/24 was around 9:30 PM-10:00 PM, she stated Resident #1 was sleeping on her right side. She stated she did not observe any bruising to her face. She stated she was never notified by her CNAs that resident had a fall. She stated she left her shift without being informed Resident #1 was found on the floor.<br><br>Interview on 04/13/24 at 2:29 PM with Student Nurse Aide revealed she had been employed since November 2023. She stated she had been assigned to the secure unit twice. She stated the last time she had worked in the secure unit was on 04/09/24 from 2:00 PM-10:00 PM. She stated she was the CNA assigned to Resident #1 on 04/09/24. She stated she completed her rounds between 7:00 PM-7:30 PM and Resident #1 was in bed sleeping. She stated when CNA G came in for her 10:00 PM-6:00 AM shift. She stated CNA G was completing her rounds when she voiced Resident #1 was not in her room. She stated she began to look for her and then she returned to Resident #1's room and found Resident #1 on the floor. She stated she called for another staff to come assist her; however, it was the first time she had observed a resident on the floor that the only thought that came to mind was to get her up. She stated she picked up the resident by herself. She stated Resident #1 did not complain of pain. She stated once she placed Resident #1 in the bed, she went to the hall and observed CNA G. She stated she notified CNA G that Resident #1 was on the floor and she picked her up and left for her shift around 10:00 PM. She stated she did not notify the nurse because she thought CNA G was going to notify the nurse. She stated the next morning on 04/10/24 she was called by the ADON asking her if Resident #1 had a fall. She stated she was told Resident #1 sustained a bruise to her forehead. She stated her mistake was not notifying the nurse. She stated she had completed her training on relias but could not recall any other in-services on falls. She stated she was in-serviced after the incident to not move the resident and to notify the nurse. She stated the potential risk of moving a resident after a fall could cause serious injuries and the risk of not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 2:57 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 3:02 PM with LVN F revealed he was the nurse assigned to Resident #1 the night of 04/09/24 from 10:00 PM-6:00 AM. He stated he completed his rounds every 2 hours. He stated Resident #1 was sleeping on her right side and they were not able to observe the bruise. He stated at around 4:00 AM-4:30AM, CNA E, assigned to the hall, notified him that Resident #1 had a bruise on her forehead. He stated he immediately assessed her and notified the Administrator. He stated he could not see any documentation regarding a fall or the bruise. LVN F stated they spoke to CNA G and CNA G stated that Resident #1 had a fall during the 2:00 PM-10:00 PM shift but was unaware if the Student Nurse Aide notified the nurse. LVN F stated he notified the doctor and family. He stated he asked Resident #1's Family Member to review the camera footage to see if Resident #1 had a fall. LVN F stated the doctor ordered x-rays and to monitor the bruise. LVN F stated by the Student Nurse Aide not notifying the nurse caused a delay in assessing the resident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/13/24 at 3:35 PM with CNA G revealed she was the assigned CNA for Resident #1 on 04/09/24 from 10:00 PM-6:00 AM for about 20 minutes. She stated on 04/09/24 closed to 10:00 PM she began her rounds. She stated she passed by Resident #1 room and Resident #1 was not in her bed. She stated she notified the Student Nurse Aide Resident #1 was not in her bed, she stated she completed her rounds while the Student Nurse Aide looked for Resident #1. CNA G stated she was not sure the what the aide's name was. She stated when she completed her rounds, the Student Nurse Aide informed her that she had found Resident #1, when she asked her where, Student Nurse Aide told her that Resident #1 was on the floor and that she had picked her up. CNA G stated when she was going to go check on Resident #1, she was called by another nurse to go 100 Hall. CNA G stated she never observed Resident #1 the night on 04/09/24. She stated she never asked the Student Nurse Aide if she had notified the nurse. CNA G stated she did not follow up on Resident #1 because she thought the Student Nurse Aide had notified someone. CNA G stated around 5:00 AM, she was asked by CNA E if she had observed Resident #1's bruise. She stated she notified CNA E and LVN F that the 2:00 PM-10:00 PM Student Nurse Aide staff had told her Resident #1 had a fall but was unsure if the Student Nurse Aide had notified the nurse. CNA G stated after she was asked about the fall it clicked on her and stated she should had followed up with the nurse. CNA G stated the risk of picking up a resident without being assess by a nurse could cause a serious injury and by not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 4:00 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 4:32 PN with the DON revealed Resident #1 had a fall the night of 04/09/24. The DON stated she was unsure how everything happened, she stated she was notified on 04/10/24, that Resident #1 had bruising to her right side of the face. She stated they spoke to Student Nurse Aide and she told them that she had found Resident #1 on the floor unknown of the time and that she picked her up. She stated she spoke to CNA G and CNA G stated that Student Nurse Aide told her that Resident #1 was found on the floor and that the Student Nurse Aide had picked her up. The DON stated the Student Nurse Aide failed to notify the charge nurse of Resident #1 being on the floor and picked her up without being assessed first. The DON stated they completed 1:1 in-serviced with Student Nurse Aide on fall prevention and reporting on 04/10/24. The DON stated staff had completed in-services prior to fall but not after the incident.<br><br>Interview on 04/13/24 at 4:48 PM with the Administrator revealed Resident #1 had a fall on 04/09/24; however, she was notified on 04/10/24. She stated she was told Resident #1 had a fall in her room and that the Student Nurse Aide transferred Resident #1 back into bed. She stated on 04/10/24, during morning stand up, they found out that the Student Nurse Aide failed to notify the nurse that Resident #1 had a fall and that she helped the Resident #1 back up without being assessed. She stated Student Nurse Aide was in-serviced after the incident.<br><br>Review of Student Nurse Aide's personnel file revealed the following forms:<br><br>Student Nurse Aide completed fall prevention training and completed the fall prevention test. Fall Prevention test dated 11/15/23, reflected one of the test questions was regarding, Once you have ensured the person's safety when discovering a fall, what is the next step? Student Nurse Aide responded: Notify the Charge Nurse.<br><br>Coaching Form - dated 04/10/24: Situation: Staff failed to report a fall.<br><br>(continued on next page) |

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Student Nurse Aide statement I [name] was making my last round w/ the aide that was working 10-6. We noticed [Resident #1] wasn't in her bed, we went checking other rooms and that's when I went back in and seen [Resident #1] on the floor as if she missed trying to sit on the bed. The first thing I did was help her off the floor onto the bed. I then asked the other aide to help me put her on the bed the right way. She said she's okay and will fix her later. I did not tell the nurse I thought maybe she would've reported it. My mistake.

Record review of the facility's Abuse/Neglect policy, revised 03/29/18, reflected the following:

The resident has the right to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Adverse Event: An adverse event is an untoward, undesirable, and usually unanticipated even that causes death or serious injury, or the risk thereof.

Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Reporting: If the allegations involve abuse or results in serious bodily injury, the report is to be made within 2 hours of the allegation.

If the allegations does not involved abuse or serious bodily injury, the report must be made within 24 hours of the allegations.

An Immediate Jeopardy was identified on 04/13/24. The Administrator was notified of the Immediate Jeopardy on 04/13/24 at 7:20 PM and was provided with the IJ template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy.

The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/14/24 8:40 AM and reflected the following:

-As of 4/10/24, Student Nurse Aide A was in-serviced 1:1 by the DON on the following: All in-servicing was completed on 4/13/24.

-Abuse and Neglect Policy

- Notification of Change in Condition: In the event of a resident incident, the nurse should immediately be notified so an assessment can be completed, and management can be notified if needed for further investigation of incident. Residents are NOT to be moved or transferred until an assessment is completed by a nurse and you are further directed by a nurse. Examples of when to notify the nurse:

- A resident is found on the floor (witnessed or unwitnessed)

- A resident has an injury that is new (bruise, skin tear, abrasion, laceration)

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | - Fall Prevention Policy<br><br>- On 4/13/24 head to toe assessments were initiated for all residents for any injuries including bruising. No additional issues were found. Assessments were completed by the DON, ADON and Tx Nurse on 4/14/24.<br><br>- The medical director was notified of the immediate jeopardy by the administrator on 4/13/24.<br><br>- AD HOC QAPI was held with the Medical Director and facility interdisciplinary team on 4/13/24 to discuss the immediate jeopardy and subsequent plan of removal.<br><br>In-services:<br><br>All staff will be in-serviced on the following topics below by the Administrator, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff and staff on leave received in-services electronically. Staff members who received in-servicing electronically must see the DON/Administrator prior to working their next shift to acknowledge understanding and sign in-services. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date: 4/14/24.<br><br>- Abuse and Neglect Policy<br><br>- Notification of Change in Condition: In the event of a resident incident, the nurse should immediately be notified so an assessment can be completed, and management can be notified if needed for further investigation of incident. Residents are NOT to be moved or transferred until an assessment is completed by a nurse and you are further directed by a nurse. Examples of when to notify the nurse:<br><br>- A resident is found on the floor (witnessed or unwitnessed)<br><br>- A resident has an injury that is new (bruise, skin tear, abrasion, laceration)<br><br>- Fall Prevention Policy<br><br>-Neuro Checks Policy (Charge Nurses Only)<br><br>Monitoring of the facility's Plan of Removal included the following:<br><br>Review of the following in-services dated 04/13/24 revealed training for Abuse and Neglect, IR (Incident Report) Reporting, Neuro Checks and Fall Prevention Policy. In-services revealed all staff completed the trainings. The in-services were conducted and signed by all facility staff on all three shifts, 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM.<br><br>Review of sample residents Assessments revealed head to toe assessments were completed.<br><br>Review of facility QAPI Meeting revealed meeting was completed on 04/13/24.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marine Creek Nursing and Rehabilitation | 3600 Angle Ave<br>Fort Worth, TX 76106 |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observations on 04/14/24 from 9:15 AM through 10:48AM revealed no other residents with bruising or injuries noted.<br><br>Interviews on 04/14/24 from 10:22 AM through 2:00 PM with CNA B, LVN C, Student Aide D, CNA G, CNA H, CNA I, RN J, CNA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA T, CNA U, CNA V, LVN W, LVN X, LVN Y, LVN Z, Treatment Nurse, Medication Aide, ADON K, ADON L, HR Coordinator, Assistant BOM, Staffing Coordinator, Medical Records, Guest Relations Coordinator, Social Worker, Dietary Manager, Dietary A, Dietary B, Dietary D, Housekeeping Supervisor, Housekeeping A, Housekeeping B, Housekeeping C, Housekeeping D, Floor Tech, Respiratory Therapist A, Respiratory Therapist B, Occupational Therapist, and Maintenance Director who worked the shifts of 6:00 AM-2:00 PM, 2:00 PM-10:00 PM and 10:00 PM-6:00 AM revealed the Staff were able to verify education was provided to them, nursing staff were able to accurately summarize what to do if a resident was found on the floor (witnessed or unwitnessed), if a resident has an injury that is new (bruise, skin tear, abrasion, laceration), fall prevention policy, and neuro checks (Charge Nurses Only).<br><br>The Administrator and DON were informed the Immediate Jeopardy was removed on 04/14/2024 at 2:15 PM. 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's need to evaluate the effectiveness of the corrective systems that were put into place. |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on observation, interview and record review, the facility failed to implement their written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 5 residents (Residents #1) reviewed for abuse and neglect.<br><br>Student Nurse Aide A, who worked the 2:00 PM-10:00 PM shift, failed to report to the charge nurse when she found Resident #1 on the floor on 04/09/24 at 9:46 PM resulting in the resident not receiving immediate treatment and care until 4:40 AM on 04/10/24, when 10:00 PM-6:00 AM staff, discovered significant bruising and injury to the resident's face/head. This failure resulted in the resident not being assessed by a nurse, not having neurological checks performed, not receiving monitoring for possible serious injury, and the physician not being notified for approximately six hours after the fall when the resident was discovered to have significant bruising and injury to the right side of her face and head. The facility failed to ensure Student Nurse Aide A knew what to do when a resident was found on floor.<br><br>An Immediate Jeopardy was identified on 04/13/24 at 7:20 PM. While the Immediate Jeopardy was removed on 04/14/24 at 2:15 PM, the facility remained out of compliance at a scope of isolated with no actual harm with a potential for more than minimal harm that is not immediate jeopardy, due to the facility's continuation of in-servicing and monitoring the plan of removal.<br><br>These failures could place residents at risk for serious injury, hospitalization and/or death.<br><br>Findings included:<br><br>Record review of the facility's Abuse/Neglect policy, revised 03/29/18, reflected the following:<br><br>The resident has the right to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms.<br><br>Adverse Event: An adverse event is an untoward, undesirable, and usually unanticipated even that causes death or serious injury, or the risk thereof.<br><br>Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>Reporting: If the allegations involve abuse or results in serious bodily injury, the report is to be made within 2 hours of the allegation.<br><br>If the allegations does not involved abuse or serious bodily injury, the report must be made within 24 hours of the allegations.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of Resident #1's face sheet, dated 04/14/24, revealed the resident was an [AGE] year-old female, who was admitted to the facility 09/08/23. Resident #1 had diagnoses which included dementia with other behavioral disturbance (impaired ability to remember, think, or make decisions), Type 2 diabetes, repeated falls, lack of coordination, unsteadiness on feet, essential hypertension (high blood pressure) and muscle weakness.<br><br>Record review of Resident #1's MDS quarterly assessment dated [DATE], revealed her BIMS score was not completed due to resident being rarely/never understood. MDS further revealed Section E - Behaviors for Wandering occurred daily. Resident #1 was able to ambulate without any mobility devices.<br><br>Record review of Resident #1's Care plan revised dated 04/12/24, revealed Focus: The resident had an actual fall r/t poor safety awareness, impulsive, impaired mobility. Goal: The resident will not sustain serious injury through review date. Interventions: Bed in lowest position. Anticipate and meet the resident's needs. Assist resident back to bed during night shift when she is ambulating and lethargic. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Bolster mattress cover to bed. Continue frequent redirection with resident in an attempt to reduce falls. Encourage resident to sit throughout the day to prevent lethargy. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. fall mat at bedside. Frequent visualization throughout the night to ensure resident safety and redirect as needed. Soft helmet when out of bed as resident tolerates to prevent head injury - refuses to wear.<br><br>Review of Resident #1's progress note documented by Physician dated 04/10/24 at 4:40 AM reflected:<br><br>Fall - Head injury. Plan: [AGE] year-old admitted to [Facility] on 9/8/2023 for rehabilitation and/or long-term care secondary to dementia. The patient has a medical history significant for dementia, diabetes mellitus, generalized anxiety, vitamin B12 deficiency hyperlipidemia and hypertension.<br><br>Plan:<br><br>1. Neuro checks as per protocol<br><br>2. Skulls Series<br><br>3. Contact DON/ADON to schedule care plan and root cause evaluation to establish what interventions are needed.<br><br>4. Hold anticoagulants, Plavix, Eliquis, Xarelto for three days if head injury visualized or suspected.<br><br>5. Consider need to send for labs if hypotensive, tachycardic or has altered mental status/increased impulsivity.<br><br>6. Order xray for relevant bony structures if patient has point tenderness/swelling on exam.<br><br>7. Tylenol 1000 mg po q8h prn pain for 72 hours.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #1's Event Nurses Note - Bruise dated 04/10/24 at 5:41 AM, revealed the following: Location event occurred - Unknown. Location of Injury: Right side of the forehead. Description: Blue/Purple, Unknown Origin. Nursing description of the event: [CNA reported that had a big purple bruise on the right side of the forehead].<br><br>Review of Resident #1's progress note documented by LVN B at 04/10/24 at 5:57 AM revealed the following: Cna reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>Review of Resident #1's Event Nurses Note - Fall dated 04/10/24 at 6:01 AM revealed the following: Location event occurred - Unknown. Unwitnessed, Hit Head. Injury - Bruise. Right side of forehead. Swelling Present, Blue/Purple. CNA reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>Review of Resident #1's Final X-Ray Report dated 04/10/24 at 15:14 [3:14 PM] revealed the following:<br><br>Examination: PELVIS, RIGHT SHOULDER, SKULL. Clinical Indication: Pain in right shoulder; pelvic and perineal pain; unspecified fall, initial encounter.<br><br>SKULL - Findings: There is no definite displaced or depressed calvarial fracture by plain film. Impression: No definite acute displaced or depressed calvarial fracture by plain film.<br><br>RIGHT SHOULDER - Findings: There is an old healed fracture of the proximal diaphysis of the right humerus. No acute fracture or dislocation is identified. Impression: No acute fracture is identified.<br><br>PELVIS - Findings: No acute fracture or dislocation. Impression: No acute osseous abnormality is seen.<br><br>Review of facility's Incident Report completed by the DON, dated 04/12/24 reflected the following: Date of Incident: 04/10/24 5:47AM - CNA reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified. Conclusion: Resident observed on the floor by aide beside her bed. Large purple bruise noted to right side of forehead and eye as a delayed injury to fall. Interventions: Frequent visualization during evening and night hours as resident becomes restless. Psych to continue to evaluate and adjust meds as indicated. Resident refuses to allow helmet to be placed on her. Continue low bed and fall mat at bedside.<br><br>Observation on 04/13/24 at 9:44 AM revealed Resident #1 in her room sleeping in B Bed with floor mats on each side of her bed. Resident #1 was covered up to her forehead. A swollen dark purple/blue bump was observed on the right side of the resident's forehead/temple.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and interview on 04/13/24 at 11:10 AM revealed Resident #1 in her room sitting on a chair. Resident #1 had significant bruising to her right side of her face. The bruise started from Resident #1's forehead, spread all the way down to her neck and both of her eyes were bruised. Resident #1 was not a good historian, and she was unable to recall having a fall. She denied being in any pain. Interview with Resident #1's Family Member revealed Resident #1 had a fall the night of 04/09/24 at 7:55 PM. She stated Resident #1 was on the floor until 4:33 AM. Resident #1's Family Member stated she had a camera in the resident's room. She stated the camera recorded footage when motion was detected and only recorded in 6 seconds increments. Review of camera footage date stamped 04/09/24 at 19:40 [7:40 PM] revealed Resident #1 was lying in bed trying to get up, and her bed was in a low position with no fall mats observed. Resident #1's bedside table, walker, and a chair on the right side of resident bed closed by. At 19:55 [7:55 PM] Resident #1 was on the floor lying on her right side. Camera footage did not show how the resident fell or if she hit herself and no sounds were made by the resident. Resident #1 was observed moving her head and left arm. At 21:46 [9:46 PM] it was observed a staff member with pink scrubs entered the room and left. The camera footage audio revealed the staff voicing while she was leaving the room at 21:46 [9:46 PM] Hey can you get the aide. At 21:58 [9:58 PM] Resident #1 was observed in bed. The camera footage did not show who or how Resident #1 was placed back in bed. Resident #1 was positioned horizontally on her right side with her feet hanging from the bed. There was no movement in the room for the camera to record from 21:58 [9:58 PM] to 4:17 AM Resident #1 was lying in bed vertical position. No observation of fall mat. At 4:33 AM a CNA was observed prepping to provide incontinence care for Resident #1, and Resident #1 was observed turning to her left side. Resident #1's Family Member stated she had a missed call from the facility on 04/10/24 at 4:59 AM and then within seconds she returned the call. She stated the facility nurse contacted her and notified her of the bruise. She stated the nurse asked her to review the cameras because they were not sure how Resident #1 sustained the bruise. She stated she reviewed the camera footage and noticed Resident #1 had the fall. Resident #1's Family Member stated she could not recall the name of the nurse who called her. She stated she had not been told much about the incident only that they had completed x-rays and results were fine.<br><br>Interview on 04/13/24 at 12:04 PM with LVN A revealed he was the charge nurse assigned to the secure unit. He stated Resident #1 bruise was noted the morning of 04/10/24 by the 10PM-6AM staff. He stated he believed Resident #1 had a fall the night of 04/09/24 unsure how; however, Resident #1 sustained a bruise to her right side of her forehead. He stated throughout the days the bruise began to spread all over Resident #1's right side of the face. LVN A stated Resident #1 was able to ambulate on her own. He stated they provided Resident #1 with a wheelchair or a walker but Resident #1 refused to use them. LVN A stated they completed an x-ray on 04/10/24 with no findings.<br><br>Interview on 04/13/24 at 12:19 PM with CNA B revealed she was the assigned CNA for Resident #1. She stated the morning of 04/10/24 she came in for her shift at around 5:45 AM, she stated she was given report that Resident #1 had a bruise to her forehead, she stated resident had a fall during the 2:00 PM-10:00 PM shift and someone had picked her up. She stated she was not provided with much information. She stated when she completed her rounds the morning of 04/10/24, she was not able to see the bruise due to Resident #1 sleeping on her right side. She stated she could not recall the CNA who noticed the bruise.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/13/24 at 12:59 PM with LVN C revealed she was the nurse assigned to the secure unit on 04/09/24 from 2:00 PM-10:00 PM shift. She stated during her shift, her CNAs were CNA H for the male side and another CNA for the female side but could not recall her name. LVN C stated her shift ended at around 11:30 PM. She stated the last time she observed Resident #1 on 04/09/24 was around 9:30 PM-10:00 PM, she stated Resident #1 was sleeping on her right side. She stated she did not observe any bruising to her face. She stated she was never notified by her CNAs that resident had a fall. She stated she left her shift without being informed Resident #1 was found on the floor.<br><br>Interview on 04/13/24 at 2:29 PM with Student Nurse Aide revealed she had been employed since November 2023. She stated she had been assigned to the secure unit twice. She stated the last time she had worked in the secure unit was on 04/09/24 from 2:00 PM-10:00 PM. She stated she was the CNA assigned to Resident #1 on 04/09/24. She stated she completed her rounds between 7:00 PM-7:30 PM and Resident #1 was in bed sleeping. She stated when CNA G came in for her 10:00 PM-6:00 AM shift. She stated CNA G was completing her rounds when she voiced Resident #1 was not in her room. She stated she began to look for her and then she returned to Resident #1's room and found Resident #1 on the floor. She stated she called for another staff to come assist her; however, it was the first time she had observed a resident on the floor that the only thought that came to mind was to get her up. She stated she picked up the resident by herself. She stated Resident #1 did not complain of pain. She stated once she placed Resident #1 in the bed, she went to the hall and observed CNA G. She stated she notified CNA G that Resident #1 was on the floor and she picked her up and left for her shift around 10:00 PM. She stated she did not notify the nurse because she thought CNA G was going to notify the nurse. She stated the next morning on 04/10/24 she was called by the ADON asking her if Resident #1 had a fall. She stated she was told Resident #1 sustained a bruise to her forehead. She stated her mistake was not notifying the nurse. She stated she had completed her training on relias but could not recall any other in-services on falls. She stated she was in-serviced after the incident to not move the resident and to notify the nurse. She stated the potential risk of moving a resident after a fall could cause serious injuries and the risk of not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 2:57 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 3:02 PM with LVN F revealed he was the nurse assigned to Resident #1 the night of 04/09/24 from 10:00 PM-6:00 AM. He stated he completed his rounds every 2 hours. He stated Resident #1 was sleeping on her right side and they were not able to observe the bruise. He stated at around 4:00 AM-4:30AM, CNA E, assigned to the hall, notified him that Resident #1 had a bruise on her forehead. He stated he immediately assessed her and notified the Administrator. He stated he could not see any documentation regarding a fall or the bruise. LVN F stated they spoke to CNA G and CNA G stated that Resident #1 had a fall during the 2:00 PM-10:00 PM shift but was unaware if the Student Nurse Aide notified the nurse. LVN F stated he notified the doctor and family. He stated he asked Resident #1's Family Member to review the camera footage to see if Resident #1 had a fall. LVN F stated the doctor ordered x-rays and to monitor the bruise. LVN F stated by the Student Nurse Aide not notifying the nurse caused a delay in assessing the resident.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/13/24 at 3:35 PM with CNA G revealed she was the assigned CNA for Resident #1 on 04/09/24 from 10:00 PM-6:00 AM for about 20 minutes. She stated on 04/09/24 closed to 10:00 PM she began her rounds. She stated she passed by Resident #1 room and Resident #1 was not in her bed. She stated she notified the Student Nurse Aide Resident #1 was not in her bed, she stated she completed her rounds while the Student Nurse Aide looked for Resident #1. CNA G stated she was not sure the what the aide's name was. She stated when she completed her rounds, the Student Nurse Aide informed her that she had found Resident #1, when she asked her where, Student Nurse Aide told her that Resident #1 was on the floor and that she had picked her up. CNA G stated when she was going to go check on Resident #1, she was called by another nurse to go 100 Hall. CNA G stated she never observed Resident #1 the night on 04/09/24. She stated she never asked the Student Nurse Aide if she had notified the nurse. CNA G stated she did not follow up on Resident #1 because she thought the Student Nurse Aide had notified someone. CNA G stated around 5:00 AM, she was asked by CNA E if she had observed Resident #1's bruise. She stated she notified CNA E and LVN F that the 2:00 PM-10:00 PM Student Nurse Aide staff had told her Resident #1 had a fall but was unsure if the Student Nurse Aide had notified the nurse. CNA G stated after she was asked about the fall it clicked on her and stated she should had followed up with the nurse. CNA G stated the risk of picking up a resident without being assess by a nurse could cause a serious injury and by not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 4:00 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 4:32 PN with the DON revealed Resident #1 had a fall the night of 04/09/24. The DON stated she was unsure how everything happened, she stated she was notified on 04/10/24, that Resident #1 had bruising to her right side of the face. She stated they spoke to Student Nurse Aide and she told them that she had found Resident #1 on the floor unknown of the time and that she picked her up. She stated she spoke to CNA G and CNA G stated that Student Nurse Aide told her that Resident #1 was found on the floor and that the Student Nurse Aide had picked her up. The DON stated the Student Nurse Aide failed to notify the charge nurse of Resident #1 being on the floor and picked her up without being assessed first. The DON stated they completed 1:1 in-serviced with Student Nurse Aide on fall prevention and reporting on 04/10/24. The DON stated staff had completed in-services prior to fall but not after the incident.<br><br>Interview on 04/13/24 at 4:48 PM with the Administrator revealed Resident #1 had a fall on 04/09/24; however, she was notified on 04/10/24. She stated she was told Resident #1 had a fall in her room and that the Student Nurse Aide transferred Resident #1 back into bed. She stated on 04/10/24, during morning stand up, they found out that the Student Nurse Aide failed to notify the nurse that Resident #1 had a fall and that she helped the Resident #1 back up without being assessed. She stated Student Nurse Aide was in-serviced after the incident.<br><br>Review of Student Nurse Aide's personnel file revealed the following forms:<br><br>Student Nurse Aide completed fall prevention training and completed the fall prevention test. Fall Prevention test dated 11/15/23, reflected one of the test questions was regarding, Once you have ensured the person's safety when discovering a fall, what is the next step? Student Nurse Aide responded: Notify the Charge Nurse.<br><br>Coaching Form - dated 04/10/24: Situation: Staff failed to report a fall.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Student Nurse Aide statement I [name] was making my last round w/ the aide that was working 10-6. We noticed [Resident #1] wasn't in her bed, we went checking other rooms and that's when I went back in and seen [Resident #1] on the floor as if she missed trying to sit on the bed. The first thing I did was help her off the floor onto the bed. I then asked the other aide to help me put her on the bed the right way. She said she's okay and will fix her later. I did not tell the nurse I thought maybe she would've reported it. My mistake.<br><br>An Immediate Jeopardy was identified on 04/13/24. The Administrator was notified of the Immediate Jeopardy on 04/13/24 at 7:20 PM and was provided with the IJ template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy.<br><br>The Facility's Plan of Removal for Immediate Jeopardy was accepted on 04/14/24 8:40 AM and reflected the following:<br><br>-As of 4/10/24, Student Nurse Aide A was in-serviced 1:1 by the DON on the following: All in-servicing was completed on 4/13/24.<br><br>-Abuse and Neglect Policy<br><br>- Notification of Change in Condition: In the event of a resident incident, the nurse should immediately be notified so an assessment can be completed, and management can be notified if needed for further investigation of incident. Residents are NOT to be moved or transferred until an assessment is completed by a nurse and you are further directed by a nurse. Examples of when to notify the nurse:<br><br>- A resident is found on the floor (witnessed or unwitnessed)<br><br>- A resident has an injury that is new (bruise, skin tear, abrasion, laceration)<br><br>- Fall Prevention Policy<br><br>- On 4/13/24 head to toe assessments were initiated for all residents for any injuries including bruising. No additional issues were found. Assessments were completed by the DON, ADON and Tx Nurse on 4/14/24.<br><br>- The medical director was notified of the immediate jeopardy by the administrator on 4/13/24.<br><br>- AD HOC QAPI was held with the Medical Director and facility interdisciplinary team on 4/13/24 to discuss the immediate jeopardy and subsequent plan of removal.<br><br>In-services:<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | All staff will be in-serviced on the following topics below by the Administrator, DON, and ADON. All staff not present will not be allowed to assume their duties until in-serviced. All PRN staff and staff on leave received in-services electronically. Staff members who received in-servicing electronically must see the DON/Administrator prior to working their next shift to acknowledge understanding and sign in-services. All new hires will be in-serviced on their date of hire, during facility orientation. All agency staff will be in-serviced prior to the start of their assignment. Completion date: 4/14/24.<br><br>- Abuse and Neglect Policy<br><br>- Notification of Change in Condition: In the event of a resident incident, the nurse should immediately be notified so an assessment can be completed, and management can be notified if needed for further investigation of incident. Residents are NOT to be moved or transferred until an assessment is completed by a nurse and you are further directed by a nurse. Examples of when to notify the nurse:<br><br>- A resident is found on the floor (witnessed or unwitnessed)<br><br>- A resident has an injury that is new (bruise, skin tear, abrasion, laceration)<br><br>- Fall Prevention Policy<br><br>-Neuro Checks Policy (Charge Nurses Only)<br><br>Monitoring of the facility's Plan of Removal included the following:<br><br>Review of the following in-services dated 04/13/24 revealed training for Abuse and Neglect, IR (Incident Report) Reporting, Neuro Checks and Fall Prevention Policy. In-services revealed all staff completed the trainings. The in-services were conducted and signed by all facility staff on all three shifts, 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM.<br><br>Review of sample residents Assessments revealed head to toe assessments were completed.<br><br>Review of facility QAPI Meeting revealed meeting was completed on 04/13/24.<br><br>Observations on 04/14/24 from 9:15 AM through 10:48AM revealed no other residents with bruising or injuries noted.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Marine Creek Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 3600 Angle Ave Fort Worth, TX 76106 | |

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| F 0607<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interviews on 04/14/24 from 10:22 AM through 2:00 PM with CNA B, LVN C, Student Aide D, CNA G, CNA H, CNA I, RN J, CNA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA T, CNA U, CNA V, LVN W, LVN X, LVN Y, LVN Z, Treatment Nurse, Medication Aide, ADON K, ADON L, HR Coordinator, Assistant BOM, Staffing Coordinator, Medical Records, Guest Relations Coordinator, Social Worker, Dietary Manager, Dietary A, Dietary B, Dietary D, Housekeeping Supervisor, Housekeeping A, Housekeeping B, Housekeeping C, Housekeeping D, Floor Tech, Respiratory Therapist A, Respiratory Therapist B, Occupational Therapist, and Maintenance Director who worked the shifts of 6:00 AM-2:00 PM, 2:00 PM-10:00 PM and 10:00 PM-6:00 AM revealed the Staff were able to verify education was provided to them, nursing staff were able to accurately summarize what to do if a resident was found on the floor (witnessed or unwitnessed), if a resident has an injury that is new (bruise, skin tear, abrasion, laceration), fall prevention policy, and neuro checks (Charge Nurses Only).<br><br>The Administrator and DON were informed the Immediate Jeopardy was removed on 04/14/2024 at 2:15 PM. 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's need to evaluate the effectiveness of the corrective systems that were put into place. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on interview and record review the facility failed to ensure all alleged violations involving neglect, which included injuries of unknown source, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials, which included the State Survey Agency, in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse and neglect.<br><br>1. Student Nurse Aide A, who worked the 2:00 PM-10:00 PM shift, failed to report to the charge nurse when she found Resident #1 on the floor on 04/09/24 at 9:46 PM resulting in the resident not receiving immediate treatment and care until 4:40 AM on 04/10/24, when 10:00 PM-6:00 AM staff, discovered significant bruising and injury to the resident's face/head.<br><br>2. The Administrator failed to report to HHSC after determining Student Nurse Aide A neglected Resident #1 by placing the resident back in bed and not notifying the charge nurse after she found Resident #1 on the floor in her room, and the resident was determined to have sustained significant bruising and injury to her face/head.<br><br>This deficient practice could affect any resident and contribute to resident neglect.<br><br>Findings included:<br><br>Review of Resident #1's face sheet, dated 04/14/24, revealed the resident was an [AGE] year-old female, who was admitted to the facility 09/08/23. Resident #1 had diagnoses which included dementia with other behavioral disturbance (impaired ability to remember, think, or make decisions), Type 2 diabetes, repeated falls, lack of coordination, unsteadiness on feet, essential hypertension (high blood pressure) and muscle weakness.<br><br>Review of Resident #1's MDS quarterly assessment dated [DATE], revealed her BIMS score was not completed due to resident rarely/never being understood. MDS further revealed Section E - Behaviors for Wandering occurred daily. Resident #1 was able to ambulate without any mobility devices. MDS revealed Section J - indicated Resident #1 had had two or more falls.<br><br>Review of Resident #1's Care plan revised dated 04/12/24, revealed Focus: The resident had an actual fall r/t poor safety awareness, impulsive, impaired mobility. Goal: The resident will not sustain serious injury through review date. Interventions: Bed in lowest position. Anticipate and meet the resident's needs. Assist resident back to bed during night shift when she is ambulating and lethargic. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Bolster mattress cover to bed. Continue frequent redirection with resident in an attempt to reduce falls. Encourage resident to sit throughout the day to prevent lethargy. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. fall mat at bedside. Frequent visualization throughout the night to ensure resident safety and redirect as needed. Soft helmet when out of bed as resident tolerates to prevent head injury - refuses to wear.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #1's progress note documented by Physician dated 04/10/24 at 4:40 AM revealed Fall - Head injury. Plan: [AGE] year-old admitted to [Facility] on 9/8/2023 for rehabilitation and/or long-term care secondary to dementia. The patient has a medical history significant for dementia, diabetes mellitus, generalized anxiety, vitamin B12 deficiency hyperlipidemia and hypertension.<br><br>Plan:<br><br>1. Neuro checks as per protocol<br><br>2. Skulls Series<br><br>3. Contact DON/ADON to schedule care plan and root cause evaluation to establish what interventions are needed.<br><br>4. Hold anticoagulants, Plavix, Eliquis, Xarelto for three days if head injury visualized or suspected.<br><br>5. Consider need to send for labs if hypotensive, tachycardic or has altered mental status/increased impulsivity.<br><br>6. Order xray for relevant bony structures if patient has point tenderness/swelling on exam.<br><br>7. Tylenol 1000 mg po q8h prn pain for 72 hours.<br><br>Review of Resident #1's Event Nurses Note - Bruise dated 04/10/24 at 5:41 AM, revealed the following: Location event occurred - Unknown. Location of Injury: Right side of the forehead. Description: Blue/Purple, Unknown Origin. Nursing description of the event: Can reported that had a big purple bruise on the right side of the forehead.<br><br>Review of Resident #1's progress note documented by LVN B at 04/10/24 at 5:57 AM revealed the following: Cna reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>Review of Resident #1's Event Nurses Note - Fall dated 04/10/24 at 6:01 AM revealed the following: Location event occurred - Unknown. Unwitnessed, Hit Head. Injury - Bruise. Right side of forehead. Swelling Present, Blue/Purple. Cna reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified.<br><br>Review of Resident #1's Final X-Ray Report dated 04/10/24 at 15:14 [3:14 PM] revealed the following:<br><br>Examination: PELVIS, RIGHT SHOULDER, SKULL. Clinical Indication: Pain in right shoulder; pelvic and perineal pain; unspecified fall, initial encounter.<br><br>(continued on next page) |

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

SKULL - Findings: There is no definite displaced or depressed calvarial fracture by plain film. Impression: No definite acute displaced or depressed calvarial fracture by plain film.

RIGHT SHOULDER - Findings: There is an old healed fracture of the proximal diaphysis of the right humerus. No acute fracture or dislocation is identified. Impression: No acute fracture is identified.

PELVIS - Findings: No acute fracture or dislocation. Impression: No acute osseous abnormality is seen.

Review of facility Incident Reported completed by DON, dated 04/12/24 revealed the following: Date of Incident: 04/10/24 5:47AM - Cna reported that Resident had a big purple bruise to the right side of the forehead, completed head-to-toe skin assessment completed, area looked tender and painful to touch, full range of motion done, patient moved all extremities in good rang of motions without pain, M/d and family notified. Conclusion: Resident observed on the floor by aide beside her bed. Large purple bruise noted to right side of forehead and eye as a delayed injury to fall. Interventions: Frequent visualization during evening and night hours as resident becomes restless. Psych to continue to evaluate and adjust meds as indicated. Resident refuses to allow helmet to be placed on her. Continue low bed and fall mat at bedside.

Observation on 04/13/24 at 9:44 AM revealed Resident #1 in her room sleeping in B Bed, observed floor mats on each side of the bed. Resident #1 was covered up to her forehead, observed a swollen dark purple/blue bump to resident right side of her forehead/temple. Unable to observe Resident #1's full face.

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation and interview on 04/13/24 at 11:10 AM revealed Resident #1 in her room sitting on a chair. Observed Resident #1 to have significant bruising to her right side of her face. The bruise started from Resident #1's forehead, spread all the way down to her neck and both eyes bruised. Resident #1 was not a good historian. Resident #1 was unable to recall fall, however, she denied any pain. Interview with Resident #1's Family Member revealed Resident #1 had a fall the night of 04/09/24 at 7:55 PM, she stated resident was on the floor until 4:33 AM. Resident #1's Family Member stated she had a camera in the resident room, she stated the camera footage were 6 seconds long and it only recorded by movement. Review of camera footage date stamped 04/09/24 at 19:40 [7:40 PM] revealed Resident #1 was lying in bed trying to get up, observed bed at low position. No observation of fall mat. Resident #1's bedside table, walker, and a chair on the right side of resident bed closed by. At 19:55 [7:55 PM] Resident #1 was on the floor lying on her right side. Camera footage did not show how the resident fell or if she hit herself and no sounds were made by the resident. Resident #1 was observed moving her head and left arm. At 21:46 [9:46 PM] it was observed a staff member with pink scrubs entered the room and left. It was heard in the camera footage the staff voicing while she was leaving the room at 21:46 [9:46PM] hey can you get the aide. At 21:58 [9:58PM] it was observed Resident #1 in bed. Camera footage does not show who or how Resident #1 was placed back in bed. Resident #1 was positioned horizontally on her right side and feet hanging from the bed. There was no movement in the room for camera to record from 21:58 [9:58 PM] to 4:17 AM Resident #1 was lying in bed vertical position. No observation of fall mat. At 4:33 AM a CNA was observed prepping to provide incontinent care to Resident #1 and Resident #1 was observed turning to her left side. Resident #1's Family Member stated she had a missed call from the facility on 04/10/24 at 4:59 AM and then within seconds she returned the call. She stated the facility nurse contacted her and notified her of the bruise noted. She stated the nurse asked her to review the cameras because they were not sure how Resident #1 sustained the bruise. She stated she reviewed the camera footage and noticed Resident #1 had the fall. Resident #1's Family Member stated she could not recall the name of the nurse who called her. She stated she had not been told much about the incident only that they had completed x-rays and results were fine.<br><br>Interview on 04/13/24 at 12:04 PM with LVN A revealed he was the charge nurse assigned to the secure unit. He stated Resident #1 bruise was noted the morning of 04/10/24 by the 10:00 PM-6:00 AM staff. He stated he believed Resident #1 had a fall the night of 04/09/24 unsure how; however, Resident #1 sustained a bruise to her right side of her forehead. He stated throughout the days the bruise began to spread all over Resident #1's right side of the face. He stated Resident #1 was a fall risk, he stated Resident #1 was able to ambulate on her own and they would provided Resident #1 with a wheelchair or a walker but Resident #1 refused to use them. LVN A stated they completed an x-ray on 04/10/24 with no findings.<br><br>Interview on 04/13/24 at 12:19 PM with CNA B revealed she was the assigned CNA for Resident #1. She stated the morning of 04/10/24 she came in for her shift at around 5:45 AM, she stated she was given report that Resident #1 had a bruise to her forehead, she stated resident had a fall during the 2:00 PM-10:00 PM shift and someone had picked her up. She stated she was not provided with much information. She stated Resident #1 was a fall risk. She stated when she completed her rounds the morning of 04/10/24, she was not able to see the bruise due to Resident #1 sleeping on her right side. She stated she could not recall the CNA who noticed the bruise.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/13/24 at 12:59 PM with LVN C revealed she was the nurse assigned to the secure unit on 04/09/24 from 2:00 PM-10:00 PM shift. She stated during her shift her CNAs were CNA H for the male side and another CNA for the female side but could not recall her name. LVN C stated her shift ended at around 11:30 PM. She stated the last time she observed Resident #1 on 04/09/24 was around 9:30 PM-10:00 PM, she stated Resident #1 was sleeping on her right side. She stated she did not observe any bruising to her face. She stated she was never notified by her CNAs that resident had a fall. She stated left her shift without being informed Resident #1 was found on the floor. LVN C stated by not reporting a fall to a nurse may delay treatment.<br><br>Interview on 04/13/24 at 2:29 PM with Student Nurse Aide A revealed she had been employed since November 2023. She stated she had been assigned to the secure unit twice. She stated the last time she had worked in the secure unit was on 04/09/24 from 2:00 PM-10:00 PM. She stated she was the CNA assigned to Resident #1 on 04/09/24. She stated she completed her rounds between 7:00 PM-7:30 PM, and Resident #1 was in bed sleeping. She stated when CNA G came in for her 10:00 PM-6:00 AM shift, CNA G was completing her rounds when she voiced Resident #1 was not in her room. She stated she began to look for her and then she returned to Resident #1's room and found Resident #1 on the floor. She stated she called for another staff to come assist her; however, it was the first time she observed a resident on the floor that the only thought that came to mind was to get her up. She stated she picked up the resident by herself. She stated Resident #1 did not complain of pain. She stated once she placed Resident #1 in the bed, she went to the hall and observed CNA G. She stated she notified CNA G that Resident #1 was on the floor, and she picked her up and left for her shift around 10:00 PM. She stated she did not notify the nurse because she thought CNA G was going to notify the nurse. She stated the next morning on 04/10/24 she was called by the ADON asking her if Resident #1 had a fall. She stated she was told Resident #1 sustained a bruise to her forehead. She stated her mistake was not notifying the nurse. She stated her mistake was considered neglect because she failed to notify the nurse. She stated she had completed training on relias but could not recall any other in-services on falls. She stated she was in-serviced after the incident to not move the resident and to notify the nurse. She stated the potential risk of moving a resident after a fall could cause serious injuries and the risk of not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 2:57 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 3:02 PM with LVN F revealed he was the nurse assigned to Resident #1 the night of 04/09/24 from 10:00 PM-6:00 AM. He stated he completed his round every 2 hours; he stated Resident #1 was sleeping on her right side throughout the night and they were not able to observe the bruise. He stated at around 4:00 AM 4:30 AM CNA E assigned to the hall notified him that Resident #1 had a bruise on her forehead, he stated he immediately assessed her and notify the Administrator. He stated he could not see any documentation regarding a fall or the bruise. LVN F stated they spoke to CNA G and CNA G had stated that Resident #1 had a fall during the 2:00 PM-10:00 PM shift but was unaware if the Student Nurse Aide had notified the nurse. LVN F stated he notified the doctor and family. He stated he had asked Resident #1 Family Member to review the camera footage to see if Resident #1 had a fall. LVN F stated the doctor ordered x-rays and to monitor the bruise. LVN F stated staff failed to report Resident #1 fall which delayed treatment.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 04/13/24 at 3:35 PM with CNA G revealed she was the assigned CNA for Resident #1 on 04/09/24 from 10:00 PM-6:00 AM for about 20 minutes. She stated on 04/09/24 closed to 10:00 PM she began her rounds; she stated she passed by Resident #1 room and Resident #1 was not in her bed. She stated she notified Student Nurse Aide A that Resident #1 was not in her bed, she stated she completed her rounds while Student Nurse Aide A looked for Resident #1. CNA G stated she was not sure the what the Aide's name was. She stated when she completed her rounds, the Student Nurse Aide informed her that she had found Resident #1, when she asked her where, Student Nurse Aide told her that Resident #1 was on the floor and that she had picked her up. CNA G stated when she was going to go check on Resident #1, she was called by another nurse to go 100 Hall. CNA G stated she never observed Resident #1 the night on 04/09/24. She stated she never asked the Student Nurse Aide if she had notified the nurse. CNA G stated she did not follow up on Resident #1. CNA G stated around 5:00 AM, she was asked by CNA E if she had observed Resident #1 bruise. She stated she notified CNA E and LVN F that the 2:00 PM-10:00 PM Student Nurse Aide A had told her Resident #1 had a fall but was unsure if Student Nurse Aide A had notified the nurse. CNA G stated after she was asked about the fall it clicked on her and stated she should had followed up with the nurse. CNA G stated the risk of picking up a resident without being assess by a nurse could cause a serious injury and by not notifying the nurse could delay treatment.<br><br>An attempt was made on 04/13/24 at 4:00 PM to contact CNA E by phone; however, there was no response.<br><br>Interview on 04/13/24 at 4:32 PN with the DON revealed Resident #1 had a fall the night of 04/09/24. The DON stated she was unsure how everything happened. She stated she was notified on 04/10/24, that Resident #1 had bruising to her right side of the face. She stated they spoke to Student Nurse Aide A, and she told them that she had found Resident #1 on the floor unknown of the time and that she picked her up. She stated she spoke to CNA G and CNA G stated that Student Nurse Aide told her that Resident #1 was found on the floor and that the Student Nurse Aide had picked her up. The DON stated the Student Nurse Aide failed to notify the charge nurse of Resident #1 being on the floor and picked her up without being assessed first. The DON stated they completed 1:1 in-serviced with Student Nurse Aide on fall prevention, and reporting. The DON stated the Administrator was responsible for reporting to the State and if the Administrator was not here it was her responsibility to report. She stated the Student Nurse Aide did failed to report to the nurse; however, this incident was not something that needed to be reported to the state.<br><br>Interview on 04/13/24 at 4:48 PM with the Administrator revealed Resident #1 had a fall on 04/09/24, and she was notified about the fall on 04/10/24. She stated she was told Resident #1 had a fall in her room and that Student Nurse Aide A transferred Resident #1 back into bed. She stated on 04/10/24 during morning stand up they found out that Student Nurse Aide A failed to notify the nurse Resident #1 had a fall and that she helped the Resident #1 back up without being assessed. She stated Student Nurse Aide A was in-serviced after the incident. She stated Student Nurse Aide A should had reported the incident; however, she made a mistake and forgot to notify the nurse.<br><br>Review of Student Nurse Aide's personnel file revealed the following forms:<br><br>Student Nurse Aide completed fall prevention training and completed the fall prevention test. Fall Prevention test dated 11/15/23, reflected one of the test questions was regarding, Once you have ensured the person's safety when discovering a fall, what is the next step? Student Nurse Aide responded: Notify the Charge Nurse.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coaching Form - dated 04/10/24: Situation: Staff failed to report a fall.<br><br>Student Nurse Aide statement I [name] was making my last round w/ the aide that was working 10-6. We noticed [Resident #1] wasn't in her bed, we went checking other rooms and that's when I went back in and seen [Resident #1] on the floor as if she missed trying to sit on the bed. The first thing I did was help her off the floor onto the bed. I then asked the other aide to help me put her on the bed the right way. She said she's okay and will fix her later. I did not tell the nurse I thought maybe she would've reported it. My mistake.<br><br>Record review of the facility Abuse/Neglect policy, revised date 03/29/18 revealed the following:<br><br>The resident has the right to be free from abuse, neglect, mistreatment, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms.<br><br>Adverse Event: An adverse event is an untoward, undesirable, and usually unanticipated even that causes death or serious injury, or the risk thereof.<br><br>Neglect: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.<br><br>Reporting: If the allegations involve abuse or results in serious bodily injury, the report is to be made within 2 hours of the allegation.<br><br>If the allegations does not involved abuse or serious bodily injury, the report must be made within 24 hours of the allegations. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675779 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/14/2024 |
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| NAME OF PROVIDER OR SUPPLIER Marine Creek Nursing and Rehabilitation | | STREET ADDRESS, CITY, STATE, ZIP CODE 3600 Angle Ave Fort Worth, TX 76106 | |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44140<br><br>Based on observation, interview and record review, the facility failed to ensure an environment that was free of accident hazards and that each resident received adequate supervision to prevent elopement for 1 of 3 residents (Residents #1) reviewed for supervision.<br><br>The facility failed to ensure Resident #1, who had severe cognitive impairment and resided on the secure unit, received adequate supervision to prevent her from wandering into the facility's enclosed courtyard without staff knowledge and being left outside for approximately 3 hours while it was raining. The facility failed to ensure the door that led to the enclosed courtyard was locked or supervised, when the door's locking mechanism lost power during the storm.<br><br>The noncompliance was identified as past non-compliance. The Immediate Jeopardy (IJ) began on 04/01/24 and ended on 04/02/24. The facility had corrected the noncompliance before the survey began.<br><br>This failure placed residents at risk of harm and/or serious injury.<br><br>Findings included:<br><br>Review of Resident #1's face sheet, dated 04/14/24, revealed the resident was an [AGE] year-old female, who was admitted to the facility 09/08/23. Resident #1 had diagnoses which included dementia with other behavioral disturbance (impaired ability to remember, think, or make decisions), Type 2 diabetes, repeated falls, lack of coordination, unsteadiness on feet, essential hypertension (high blood pressure) and muscle weakness.<br><br>Record review of Resident #1's MDS quarterly assessment dated [DATE], revealed her BIMS score was not completed due to resident is rarely/never understood. MDS further revealed Section E - Behaviors for Wandering occurred daily. Resident #1 was able to ambulate without any mobility devices.<br><br>Review of Resident #1's care plan, dated revised 04/03/24, reflected: Focus: The resident wanders throughout the day and night. Goal: Resident will demonstrate happiness with daily routine through the review date. Resident safety will be maintained through review date. Interventions: Assess for fall risk. Disguise exits: cover door knobs and handles, tape floor. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc. The resident will reside in the secure unit.<br><br>Focus: Resident is at risk for elopement as evidenced by impaired safety awareness, attempts at leaving facility, pulling and banging on doors in an attempt to leave the secured unit. Goal: [Resident #1] will remain safe within facility unless accompanied by staff or other authorized person through review date. Intentions: Supervise closely and make regular compliance rounds whenever resident is in room. If the resident is exit seeking, stay with the resident and notify the charge nurse by calling out, sending another staff member, call system, etc.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Focus: Resident resides in the SecureCare Unit, related to diagnosis of dementia (or related diagnosis) and risk for elopement. Memory loss. Goal: Resident will not have feelings of isolation and will feel safe and secure in the care received while on the SecureCare Unit. Interventions: Admit to SecureCare unit per MD orders. Engage resident in group activities and provide them with individualized meaningful projects that they will accomplish throughout the day.<br><br>Review of Resident #1's Elopement Risk assessment dated [DATE] revealed Resident #1 resided in the secure unit; Cognitive skills for daily decision making - severely impaired -never/rarely made decision; history; one or more times in last week; Behaviors - Restlessness (pacing, wandering or rummaging).<br><br>Review of Resident #1's Elopement Risk assessment dated [DATE] revealed Resident #1 resided in the secure unit; Cognitive skills for daily decision making - severely impaired -never/rarely made decision; history; one or more times in last week; Behaviors - Restlessness (pacing, wandering or rummaging).<br><br>Review of Resident #1's progress notes by LVN AB on 04/02/24 at 00:57 revealed the following: Resident missing from the unit, later found lying on the ground in the courtyard, no bruise/injury noted on full assessment, no pain verbalized in full range of motion, Resident assisted up in w/c, taken to the shower room, given warm bath, assisted to bed, covered with warm blanket, M/d family notified.<br><br>Review of Resident #1's progress notes by DON on 04/02/24 at 11:30 revealed the following: Note Text: DON went to secured unit to re-assess resident and ensure no injury r/t resident being observed on the grass beside the sidewalk in the courtyard on the night of 4/1/24. Resident was observed on the couch in the tv room sleeping. Resident stated to staff that she was not having pain, but would not stand from the couch to allow DON to fully assess her. CNA that gave resident shower on 4/1/24 stated she did not see any new injury related to this incident, there are some healing bruises noted to resident's skull from prior fall and scattered bruises to BUE from resident wandering and her unsteady gait. DON could assess BUE, back, abdomen, and BLE up to her knees; no new injuries noted. Will remain available to resident and staff.<br><br>Review of facility Provider Investigation Report dated 04/05/24 revealed the following: Incident Category: Neglect; Incident Date 04/01/24; Time of Incident: 8:30 PM; Location of Incident: Resident out into courtyard; Description of the Allegation: Resident was not accounted for during walking rounds by nurses at shift change. Assessment: Date 04/01/24 at 11:30PM by LVN F; No noted injuries or behavioral changes from baseline. Head to toe assessment was completed. Xrays and labs ordered along with CT Scan out of the facility. All residents were counted visually as staff continued with the missing resident protocol. All xrays and CT Scan were negative for any new fractures. Investigation Findings: Confirmed; Provider Action Taken post-investigation: Abuse and neglect in serviced completed; missing resident protocols inserviced and drills completed and will continued to monitor and perform drills. Door was checked by outside vendor and I secure; door codes changed.<br><br>Review of Resident #1's Final X-Ray Report completed 04/02/24 revealed no acute fractures or dislocations.<br><br>Review of Resident #1 Ct Head Without Contrast completed 04/04/24 revealed no acute intracranial abnormality.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation on 04/13/24 at 9:44 AM revealed Resident #1 in her room sleeping in B Bed, observed floor mats on each side of the bed. Resident #1 was covered up to her forehead, observed a swollen dark purple/blue bump to resident right side of her forehead/temple. Unable to observed Resident #1 full face.<br><br>Observation and interview on 04/13/24 at 11:10 AM revealed Resident #1 in her room sitting on a chair. Resident #1 was not a good historian. Resident #1 unable to recall going outside, however, she denied any pain. Interview with Resident #1 Family Member revealed she was notified of Resident #1 leaving the secure unit and being outside the enclosed courtyard. She stated Resident #1 wandered around and walked all over the secure unit. Resident #1's Family Member stated they completed x-rays and CT scans were done with no negative results.<br><br>Review of the facility's surveillance footage dated 04/01/24 at 18:26 [6:26 PM] revealed Resident #1 walking towards the secure unit living room area. Observed double doors being closed. Resident #1 opened the living room area door and was walking towards the courtyard door. However, since the camera was not facing the door, it was not captured when Resident #1 opened and exited the door.<br><br>Interview on 04/13/24 at 1:08 PM with the Administrator revealed the date stamp in the camera footage was off. She stated the time was not correct. The Administrator stated she received a call at around 10:00 PM on 04/01/24 stating that Resident #1 was missing. She stated she contacted the Maintenance Director and asked him to review the camera footage. She stated she arrived at the facility at around 10:30 PM and she received a call from the Maintenance Director telling her to look in the enclosed courtyard. She stated Resident #1 was found around 11:00 PM. She stated the 2:00 PM-10:00 PM LVN was LVN AB and the 10:00 PM-6:00 AM was LVN F. The Administrator stated CNA S placed Resident #1 in bed at 7:20PM and Resident #1 got up and began to walk around the secure unit. She stated the enclosed courtyard had a door code, and it was unknown how Resident #1 was able to open the door. She stated the night of 04/01/24, it was raining and the light flickered and they believe that in that moment when the light [NAME] Resident #1 open the door. She stated when Resident #1 was found outside, she was laying on the floor, and Resident #1 was damped (slightly wet). She stated they gave Resident #1 a warmed bath and no injuries were noted. She stated X-rays and CT were completed and results were negative.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Observation and interview on 04/13/24 at 1:20 PM of Secure Unit courtyard door with Maintenance Director revealed the door was closed, was unable to be opened without the code. Observed Maintenance Director punch in the door code and door open. Observed additional alarm added to the door; alarm was heard and it was loud. Maintenance Director stated he received a call at around 10:30PM the night of 04/01/24 form the Administrator. He stated he was asked to check the camera footage and he observe Resident #1 walking in the living room toward the courtyard door. He stated the camera was not facing the door so it was unknown how Resident #1 was able to open the door. The Maintenance Director stated the time on the camera footage was off and they cannot go by the time the camera footage was stamped. He stated he notified the Administrator around 11:00 PM to check the enclosed courtyard. He stated the courtyard door needs a code to open it, he stated the night of 04/01/24 it was raining and CNA G stated the lights were flickering. He stated when the light [NAME] they believed that was the time Resident #1 was able to open the door. The Maintenance Director stated since the incident they had in serviced all staff on elopement/missing person, the staff were checking doors every 15 minutes starting from 04/02/24 through 04/11/24. He stated they completed elopement drills on 04/02/24, 04/07/24 and will continue randomly. He stated they had the alarm company come out on 04/02/24 to check the doors, they implemented an additional alarm on the door and door codes would be changed monthly. He stated the alarm company came out and stated due to the light flickering the magnet on the door detached and did not grip on time. He stated they replaced the door closure with a stronger spring.<br><br>Interview on 04/13/24 at 2:05 PM with LVN AB revealed he was the nurse assigned on the secure unit and was the nurse for Resident #1 on 04/01/24 from 2:00 PM-10:00 PM. LVN AB stated Resident #1 was able to ambulate on her own without assistance. He stated Resident #1 was known to wander around. He stated on 04/01/24, the last time he observed Resident #1 was between 7:00 PM-8:00 PM when he provided her with her night medications. He stated during shift change at 10:00 PM he was notified by incoming night staff that Resident #1 could not be located. He stated they began to look for Resident #1 in each room, closets, restroom, dining area, living room and all around the secure unit. He stated they notified the Administrator and the Administrator contact the Maintenance Director for him to review camera footage. He stated at around 10:45 PM close to 11:00PM, Resident #1 was found outside in the courtyard lying on the grass. He stated the courtyard door only opened with a code. He stated he did not know how Resident #1 was able to open the door. He stated he could not remember any lights flickering and denied hearing an alarm. He stated Resident #1 was slightly wet due to the rain. He stated they brought Resident #1 inside and gave her warm bath. LVN AB stated Resident #1 did not sustain any injuries. He stated Resident #1 was her normal self and could not recall the event.<br><br>Interview on 04/13/24 at 2:58 PM with LVN F revealed he was the incoming nurse for the 10:00PM-6:00AM shift on 04/01/24. He stated he was completing his rounds and he was not able to locate Resident #1. He stated it was a little after 10:00PM when they were not able to locate Resident #1. He stated he contacted the Administrator to notify her Resident #1 was not able to be located after looking everywhere in the secure unit. He stated he told the Administrator to look at the video footage starting from 8:00PM. He stated the Maintenance Director was able to look at the camera footage and the Maintenance Director told them to look in the courtyard. LVN F stated they found Resident #1 outside in the enclosed courtyard. LVN F stated he could not recall the time Resident #1 was found. He stated Resident #1 was provided with a warm bath and no injuries were noted. LVN F stated no one goes into the enclosed courtyard. He stated the door had a code and it was unknown how Resident #1 was able to open it.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Interview on 04/13/24 at 3:35 PM with CNA G revealed she was the incoming CNA assigned to the secure unit on 04/01/24 from 10:00 PM-6:00 AM. She stated she was completing her rounds closed to 10:00PM when she asked the 2:00 PM-10:00 PM aide where Resident #1 was. She stated she could not recall who the aide was. She stated when she asked the aide, the aide told her Resident #1 was here somewhere but not sure where Resident #1 was. She stated she notified LVN F and they began searching for Resident #1. She stated the nurses notified the Administrator and within 30-45 minutes Resident #1 was found outside in the enclosed courtyard. CNA G stated the night of 04/01/24 it was raining. She stated she did not know if the door was open or closed; however, to open the courtyard door they needed a code. She stated no one went out to the enclosed courtyard. She stated the secure unit had another courtyard that they use. She stated Resident #1 was given a warm bath and no injuries were noted.<br><br>Interview on 04/13/24 at 3:53 PM with CNA S revealed she was the CNA assigned to Resident #1 on 04/01/24 from 2:00PM- 10:00PM. She stated on 04/01/24 she had placed Resident #1 in bed at around 7:00PM - 7:15PM; however, Resident #1 got up again and began to walk around. She stated she left her shift at around 9:45PM close to 10:00PM. She stated she last time she observed Resident #1 was on the hallway; however, she could not recall the time. CNA S stated she did not hear any alarms go off. She stated they did not use the enclosed courtyard. She stated they had another courtyard normally used. She stated the enclosed courtyard door needed a code to open and it was unsure how Resident #1 opened it. She stated she did not recall any lights flickering; however, it was raining outside.<br><br>Interview on 04/13/24 at 4:32 PM with the DON revealed the night of 04/01/24 Resident #1 went missing in the secure unit. She stated she began her investigation on 04/02/24. She stated she spoke to CNA S and CNA S stated she had placed Resident #1 in bed around 7:30PM and Resident #1 got up from bed and was walking around the secure unit. She stated LVN AB stated he last observed Resident #1 when he provided resident with her night medications between 7:00PM-8:00PM. She stated at around 10:00PM during shift changed they noticed Resident #1 could not be located. The DON stated Resident #1 was found in the courtyard laying on the grass around 10:30PM. She stated the night of 04/01/24, it was raining and CNA S reported the lights were flickering and they believed during the time the lights [NAME] was when Resident #1 open the enclosed courtyard door. The DON stated the courtyard door needed a code to be opened. She stated she did not even know the code to the door. She stated no one used the enclosed courtyard. She stated when she was investigating the incident, she tried to open the courtyard door without the code and the door would not open. She stated they changed the door code and it would be changed monthly. She stated they implemented a new alarm on the door, they in-serviced all staff on elopement/missing person, staff would check the doors q15 , and alarm company came out to check the doors. She stated Resident #1 had no injuries and her behavior was her normal. She stated they completed x-rays and CT scan without no findings.<br><br>Follow-up interview on 04/13/24 at 4:48 PM with the Administrator revealed they in-serviced all staff on missing person, they conducted missing person drills which consist of getting a volunteer resident and having staff search for that resident. She stated had the alarm company come out and implemented a new alarm and will be changing the door alarm every month. She stated the alarm company came out and stated due to the light flickering the magnet on the door detached and did not grip on time.<br><br>Record review of the facility's Elopement Response policy and procedure, revised January 2023, reflected the following: Nursing personnel must report and investigate all reports of missing residents. When an elopement has occurred or is suspected, our elopement response plan will be immediately implemented.<br><br>(continued on next page) |

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| | 675779 | A. Building<br>B. Wing | 04/14/2024 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 4. Should an employee discover the resident missing from the facility (Code Orange) .<br><br>Record review of the facility's Elopement Prevention policy and procedure, revised January 2023, reflected the following: Every effort will be made to prevent elopement episode while maintaining the least restrictive environment for residents who are at risk of elopement.<br><br>This was determined to be a Past Non-Compliance Immediate Jeopardy on 04/13/24 at 7:20 PM. The Administrator and the DON were notified. The Administrator was provided with the IJ template on 04/13/23 at 7:20 PM.<br><br>The facility took the following actions to correct the non-compliance prior to the survey:<br><br>Record review of the following in-services dated 04/02/24 Elopement Response, Elopement Prevention and Code Orange. In-service reveal all staff completed the training. The in-services were conducted and signed by all facility staff on all three shifts, 6:00 AM to 2:00 PM, 2:00 PM to 10:00 PM and 10:00 PM to 6:00 AM.<br><br>Review of Resident #1's Elopement Risk Assessment completed on 04/02/24; Resident #1 resided in the Secure unit.<br><br>Door codes on 500 Hall unit changed on 04/03/24. Replaced door with closure with a stronger grip. Added additional alarm to exit door to courtyard. Alarm installed made louder upon opening without code and or left ajar.<br><br>Observation on 04/13/24 at 1:20 PM revealed exit door on the secure unit courtyard door was checked with the Maintenance Director and door was functioning properly. There was an additional louder alarm added so they could be heard throughout the facility if the doors did not latch after being open.<br><br>Interviews on 04/13/24 from 12:04 PM through 5:00 PM with LVN A, CNA B, CNA M, LVN C, LVN AB, Student Nurse Aide, CNA G, CNA H, LVN F, CNA S, CNA AC, CNA AD, CNA O, RN J, Treatment Nurse, ADON L who worked the shifts of 6:00 AM-2:00 PM, 2:00 PM-10:00 PM and 10:00 PM - 6:00 AM revealed they were able to verify education was provided to them. Nursing staff were able to accurately summarize missing person/elopement policy, missing/elopement code, missing person drills, and door checks.<br><br>Interview on 04/14/24 from 10:22 AM through 2:00 PM with CNA I, CNA Q, HR Coordinator, LVN W, LVN X, Guest Relations Coordinator, ADON K, LVN Y, CNA U and CNA V who work the shifts of 6:00 AM-2:00 PM, 2:00 PM-10:00 PM and 10:00 PM-6:00 AM revealed they were able to verify education was provided to them, nursing staff were able to accurately summarize missing person/elopement policy, missing/elopement code, missing person drills, and door checks.<br><br>Record review of the Facility's Door Checks date 04/02/24 at 2:00 PM through 04/11/24 door checks were completed every 15 minutes<br><br>Record review of the facility's Elopement Drills or Actual Elopement Guide revealed drills were conducted on 04/02/24 and 04/07/24. |