STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675790	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews and record reviews, the facility failed to immediately consult with the resident's physician; and notify, consistent with his or her authority, when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for one (Resident #1) of six residents reviewed for Change in condition. LVN B failed to notify Resident #1's Doctor on 08/02/24 after CNA A asked her to assist with picking Resident #1 off the floormat and putting her back to bed. Subsequently, Resident #1 was sent to the hospital on 08/08/24 and currently at the hospital diagnosed with two fractures (Tibia and Fibula) of her left lower leg. An Immediate Jeopardy (IJ) was identified on 08/12/24. An IJ Template was provided to the facility on [DATE] at 12:10 pm. While the Immediate Jeopardy was removed on 08/12/24 at 7:50 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place all residents at risk of not being assessed and treated in a timely manner and appropriately, with Doctors interventions, which could result in a decline in their psycho-social well-being and health resulting in internal bleeding, pain when being moved causing further injury or death. Findings included: (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old female who admitted [DATE] with a BIMS Staff Assessment score of 2 (Moderate impaired cognition), no speech, with a memory problem and severely impaired. She had upper extremity impairment on one side and lower extremity impairment of both sides. Her functioning abilities and goals: Self-care: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for all ADLs including (toileting, personal hygiene). Her functioning abilities and goals: Mobility: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for roll left and right and for chair/bed to chair transfer. She was always incontinent to bladder and bowel, has a progressive neurological conditions with diagnoses of hypertension. She had Multiple Sclerosis (nerve degeneration), Gastronomy status (feeding tube), Cardiac arrhythmia (irregular heartbeat), dysphagia (not able to swallow properly), muscle weakness, atrial fibrillation (irregular heartbeat), and lack of coordination. She was 5'6 and 132 pounds. Record review of Resident #1's August 2024 Order Summary Report revealed orders for: Eliquis (blood thinner) 5 mg, folic acid 1 mg. senna 8.6 mg. tramadol 50 mg. Enteral Feeding tube, Enteral stoma site care, NPO, Enteral formula pump administration. Record review of Resident #1's Care Plan printed 8/10/24 revealed, Multiple sclerosis: assist with ADL and comfort measures as needed, Abdominal binder: to keep G-tube in place keep head and bed elevated. Geri-chair: make as comfortable as possible, falls (Resident has a history of falling related to mobility due to Multiple Sclerosis): place resident in a fall prevention program. Multiple sclerosis at risk for a decline in current ADLs and injuries due to increased injuries and assist with ADL's and comfort measures as needed. Cognitive loss/dementia: allow time for task and responses. Communication has aphasia approach in calm manner. Falls - keep call light within reach, ADL Functional status: ambulation/transfers amount of assist: total x 2 non-ambulatory, bathing/hygiene assist: total x1, resident care as per policy, toileting amount of assist total x1. Record review of Resident #1's Progress notes reviewed from 08/02/24 to 08/09/24 did not reveal she had any falls or incidents. Record review of Resident #1's X-Ray results dated 08/08/24 at 8:03 p.m. revealed, Clinical information: Bruising, swelling, Test procedures: Left tibia and fibula, two views. Findings: Proximal tibial and fibular shafts fracture. No osteolytic or osteosclerotic lesions. No signs of bone infection. Impression:1. Proximal tibial and fibular shafts fracture. 2. CT is recommended. Record review of Resident #1's Hospital Emergency Department Doctor's note dated 08/08/24 revealed, Chief complaint: Leg deformity: patient here from [Nursing Facility]. Left leg swelling noted and ecchymosis found this morning. On Eliquis .Patient is bed bound and nonverbal. Radiology: Tibia/fibula, left 2 views final result: Impression: Proximal left tibial and fibular fractures, negative left ankle and knee joint. Soft tissue swelling. Osteopenia. Record review of Resident #1's Progress note 08/02/2024 [Recorded as Late Entry on 08/09/2024 06:19 PM] by LVN B revealed, Events - fall: 11:06 PM On 2nd of August, CNA call attention to this nurse to room XXXX and reported to this nurse that she rolled resident down to the floor mat while giving care. Observed and assess resident on the floor mat., no apparent injury noted at that time. No S/S of pain noted at that time. Resident was helped back to bed with the help of the CNA. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Incident/Accident Report completed date 08/09/24 at 6:08 p.m. by LVN B revealed, Event date 08/02/24 at 5:57 p.m., in resident room, yes fall was witnessed, no injury and no pain, ROM without pain/limitations, no rotation/deformity/shortening noted .notifications: Attending physician faxed: no, Physician notified: no, Resident Representative notified: no, care plan reviewed: no. Record review of Resident #1's Hospital Orthopedic Doctor note dated 08/09/24 revealed, Orthopedic diagnosis: Left Proximal tibia fracture. Orthopedic plan: Closed management of left proximal tibial fracture, knee immobilization, non-weight bearing. History of present illness: A [AGE] year-old female with multiple advance medical issues including MS, who is nonverbal at baseline .The patient is nonverbal, non-ambulatory. I do not think she would be a very good candidate for surgical intervention. I will plan for a knee immobilization and follow-up in the outpatient setting. Observation on 08/09/24 at 3:40 p.m., Resident #1's room revealed a thin blue floormat that was approximately two inches height and six feet in length on the left side of Resident #1's bed. Observation on 08/10/24 at 3:37 p.m., Resident #1 was at the hospital lying flat on her back, in bed watching television, she nodded yes to her name. She shook her head no she was not hurting. When asked had she fallen out of bed, she looked at her left leg and did not shake or nod her head. There was a G-tube next to her bed and she did not appear to be in pain. And her left leg was bent at a 45-degree angle with a knee immobilizer on it. Interview on 08/09/24 at 6:43 p.m., CNA A stated on 08/02/24 after dinner she checked Resident #1 and incontinent care was needed. She stated she was standing right in front of the window with the bed elevated and while caring for Resident #1, she turned her towards the door then towards her. She stated she put the bed linen on the floor then rolled her to the right to clean her and afterwards she tried to grab her bed sheets at the foot of her bed. She stated then Resident #1 started shaking and rolled off the bed so she went to get LVN B who came to assess the resident and made sure she was okay. She stated she and LVN B got Resident #1 back to bed and got her dressed then LVN B asked her what happened and she told her she was doing incontinent care and the resident rolled to the floor. She stated Resident #1 was nonverbal but did not appear to be in any pain and her leg was not swollen or in a weird position. She stated she was not sure if the nurse called to have any x-rays done and did not see anyone come out to do x-rays during her shift. She stated there was most likely no x-rays done because the resident was not crying because she checked on her frequently and changed her about four more times that night. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/10/24 at 9:09 a.m., LVN B stated she worked the overnight shift and last took care of Resident #1 Last Friday 08/02/24, Tuesday 08/06/24 and Wednesday 08/07/24. She stated yesterday 08/09/24 she heard Resident #1 had a leg fracture. She stated she was very surprised Resident #1 was injured. She stated the DON spoke to her about what she knew about Resident #1's fall on 08/02/24 then the DON told her she should have completed an incident report and called her Doctor. She stated she did a late add nurses note and incident/accident report on 08/09/24 per the DON's request. She stated last Friday 08/02/24 after meal service, after 11:00 pm she was at the nurses' station and CNA A stood at Resident #1's room door calling her name out loud about needing help putting Resident #1 back to bed. She stated she saw Resident #1 in her room and her bed was in the lowest position and Resident #1 was on the left side of her bed on the floor. She stated Resident #1 was on her back and her left leg was turned to the left, and her head and buttocks was flat on the floormat, she was on her back. She stated her left leg was paralyzed and for her care they normally used a pillow to prop it in place. She stated when Resident #1 was on the floor her G-tube port was okay and the tubing was still connected to the g-tube pump. She stated there was no pillow under Resident #1's leg and the bed linen and pillow was on her bed. She stated she assessed Resident #1 and did not find anything wrong with her and she had no signs or symptoms of pain, then she CNA A put her back to bed. She stated when she asked CNA A why Resident #1 on the floor, CNA A said she rolled Resident #1 onto the floor to give her incontinent care. She stated CNA A did not say Resident #1 fell but said she guided her to the floormat. She stated if CNA A told her Resident #1 had fallen, she would have reported it to her Doctor. She stated she would have also documented it in Resident #1's nurses notes and completed an incident report and called her family. She stated she would have followed up with her to ensure she was fine and added Resident #1 was on scheduled Tramadol she received at 12:00 am and PRN Tylenol. She stated there was no increase in giving her more pain medications. She stated Resident #1's floor mat next was next to her bed 24/7 and Resident #1 normally did not get care on the floor mat that was why can questioned CNA A about it. She stated there was not anything propping her left leg, she checked on Resident #1 four or five times that night. She stated Resident #1 watched television and slept and she was given her Tramadol at midnight and she was asleep rest of the night. She stated she did not tell the oncoming nurse or the DON about her being on the floor because she got busy and did not suspect anything was wrong. She stated she got busy with taking care of other residents forgot to document at nurses note. She stated there was no swelling or redness of her legs during her 08/02/24 shift. She stated she returned to work Tuesday 08/06/24 the nurse reported Resident #1 had left leg swelling and her Doctor ordered for a doppler study for edema. She stated the doppler study result came back Wednesday 08/07/24 was negative and she faxed that result to her Doctor. She stated there were no new orders and she took a picture of Resident #1's left leg and sent it to her Doctor. She stated she got a call from the DON yesterday 08/09/24 around 4:00 pm and she returned the call around 4:49 pm and the DON told her to come to the facility. She stated a little after 5:00 pm she gave the DON her statement and completed Resident #1's incident report. The DON told her she should have reported this to her and called her Doctor and family. She stated she had the mind to call the DON but forgot and stated if a resident fell and the Doctor, DON or family was not notified could result in delayed injury. She stated that was why she always documented but she forgot to document Resident #1's fall and said after the DON spoke to her, she now knew why she should have completed a nurses note and reported it to her Doctor and family. She stated she thought it was odd Resident #1 was on the floormat. She stated Resident #1 was bed bound with left sided weakness, upper and lower and alert and oriented x1. She stated Resident #1 was not able to express her needs because she was aphasic and knew her name. She stated Resident #1 was able to gesture responses by nodding and shaking her head. She stated the nurses were responsible for ensuring the residents were getting proper care and cleaned and dry and checked every 2 hours. She stated the DON suspended her and CNA A pending the investigation of Resident #1. She stated not reporting something bad could cause the resident to get bruised, get skin tears or injured. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 4:45 p.m., The Police Detective stated he visited Resident #1 at the hospital and gathered other information and opened a case to further investigate the circumstances involving Resident #1's leg injury. He stated he had spoken to CNA A who said on 08/02/24 she was cleaning Resident #1 and she turned around then the resident kept rolling and fell out of the bed. He stated CNA A said she asked LVN B to help get Resident #1 off of the floor then LVN B picked up Resident #1 and put her back onto her bed. Police Detective stated as of right now there was no documentation of the resident falling and no one knew what happened to her leg and the resident was not able to say what happened. He stated the Administrator and DON said they just discovered it from CNA A's statement. He stated Resident #1 sustained two fractures of her left tibia and left fibula that was approximately one inch below her knee. He stated Resident #1's roommate said she remembered a nurse and CNA coming in really fast one night but was not able to see or know what happened. He stated he was getting ready to interview LVN B to gather more information. Interview on 08/09/24 at 7:26 p m, the DON stated she received a report on 08/06/24 about Resident #1's left leg appearing shiny and red like she had irritated rash. She stated her Doctor ordered a doppler study of her left leg and the results came back negative. She stated the area on her leg started swelling up more and getting darker red and her Doctor diagnosed her with cellulitis and ordered antibiotics. She stated yesterday 08/08/24 her leg was still looking red and her Doctor ordered an X-ray and the result came back yesterday morning for two fractures of her left tibia and fibula. She stated she was just finding out today 08/09/24 around 4:30 pm Resident #1 fell Friday night on 08/02/24. She stated there were no notes in her medical records and no incident reports. She stated they were currently doing in-service trainings with all staff and doing skin and pain assessments of all the residents. She stated the staff trainings were on notifications to the resident's Doctor and did 1:1 trainings with LVN B and now they were training all staff. She stated it was too early in her investigation and was not sure if Resident #1 was a 1 or 2 person assist for ADL's but said she would follow-up with the surveyor. She stated CNA A said she was doing Resident #1's incontinent care and when she turned to get some linen, Resident #1 rolled out of her bed. She stated CNA A told her that LVN B was alerted and Resident #1 was assessed but there was not any documentation of a nurses note and no notifications to her Doctor. She stated LVN B confirmed everything that happened she went into the room the resident was on the floor, and CNA A explained she had guided the resident to the floor. She stated LVN B said she did a head-to-toe assessment and when asked why she did not document the assessment LVN B said it got so busy and she forgot. The DON stated today 08/09/24 she informed Resident #1's Doctor about Resident #1's fall with injury and he was upset because no one had called him 08/02/24. She stated the Doctor was at the facility visiting patients Monday 08/05/24 and no one told him about this until today. She stated ADON C assessed Resident #1 then she was transferred to the hospital. She stated she spoke to LVN B on 08/09/24 around 4:00 pm she confirmed Resident #1 had fallen on 08/02/24. She stated LVN #1 was suspended. She stated LVN B came to the facility to drop off her statement and said she had not worked in the past two days. She stated Resident #1 was not able to express her needs but was good at communicating by nodding and shaking her head. She stated Resident #1 required the use a wheelchair and was not sure if she could move her legs but was in the process of finding out more. She stated unreported and undocumented falls could have adverse effects because neuro checks needed to be done to monitor if they had a change of mental status, got injured or needed more pain medications. She stated Resident #1 had routine pain medication and since 08/02/24 and she had not had any increased pain. She stated after Resident #1 fell her Doctor should have been called and the fact that CNA A said the resident fell off the bed, LVN B should have called her Doctor for further instructions. She stated the last she heard the hospital were not going to do surgery to repair her left tibia and fibula because of her MS diagnosis. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 8:21 p.m., the Administrator stated he found out Resident #1 fell [DATE] and they were currently doing their investigation. He stated today 08/09/24 CNA A said Resident #1 fell last Friday 08/02/24 and that she and LVN B got her back into bed and they suspended her. He stated they called LVN B to tell them her story and she was interviewed then they decided to suspend LVN B pending investigation for not following their events protocol procedure. He stated yesterday 08/08/24 Resident #1 was transferred to the hospital after her x-ray result showed she had fibula and tibia fractures of her left leg. He stated ever since then they were doing employee trainings on reporting events. He stated the DON and ADON were responsible for ensuring the nursing staff were following their protocols. He stated they reviewed all of Resident #1's documentation today and there was not any documentation about her falling. He stated unreported and undocumented falls could cause all kinds of things to happen such as pain, worsening condition, tons of things, no follow up on the resident's status. He stated they spoke to the Medical Director about Resident #1's fall with injury and they planned to continue to do trainings and get statements from the staff. He stated they were reviewing her documents and other residents to protect all the residents and to see if they could do something another way to communicate better. Interview on 08/10/24 at 11:00 a.m., with the Hospital RN stated Resident #1 admitted to the hospital because of a fractured tibia and fibula. She stated she was stable right now and was currently awake but nonverbal and just nodded in agreement to everything and was not good at following commands. She stated Resident #1 did not appear to be in any pain and no surgery was planned yet and they were doing conservative treatments on her. She stated there were no discharge plans at this time and her pain levels were fine but grimaced when providing care then but when still she had no signs or symptoms of pain. She stated she had not been given any pain medications since she admitted on [DATE] but had Doctor orders for Norco for moderate pain. She stated she Resident #1 has Doctor orders for Ativan for anxiety, morphine for severe pain and Tylenol for mild pain/headache. She stated Resident #1 had an immobilizer on her left leg and stated both her arms were contracted (right arm moved a little more and her left arm was more contracted). She stated her left leg was completed contracted and stated she was a 2 person assist because it was hard to turn her because she was very stiff. She stated Resident #1 was given 4 mg. of morphine on 8/8/24 at 10:15 pm in the ER via her G-tube. Interview on 08/11/24 at 1:45 p.m., the DON stated they updated the staff trainings that were conducted by herself and Nursing Supervisors RN G and LVN H. She stated they were reviewing the other resident's records to see if any other residents were affected no other residents were affected. She stated they started notification of changes trainings on 08/09/24. She stated she they started doing Resident's skin and pain assessments on Friday morning of 08/09/24. She stated LVN B said CNA A told her while giving Resident #1 incontinent care CNA A guide rolled the resident to the floor. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/11/24 at 2:28 pm, ADON C stated last Tuesday 08/06/24 LVN D reported Resident #1 had redness of her left leg and her Doctor was called and he ordered for her to get a doppler study that came back negative. She stated on Thursday 08/08/24 LVN O reported something was going on with Resident #1's left leg was swollen and the color was reddish and greenish. She stated she assessed Resident #1's left leg and tried to move her leg but when she moved her leg back the resident flinched her leg back. She stated she asked her was she in pain and she moved head but it was not a distinct nod or shake. She stated she asked Resident #1 was her leg in pain and she gestured yes. She stated she was not crying or appeared to be in pain and noticed the upper part of chin had discoloration and swelling from under her kneecap to her lower leg. She stated she notified Resident #1's Doctor herself and he ordered doxycycline, x-ray and lab work and she contacted her FM. She stated when her x-ray results came back showing she had a fractured tibia and fractured fibula shaft, they sent her to the hospital. She stated Resident #1 was a Hoyer lift transfer resident and she was a 1-person physical assist for incontinent care/bed mobility. She stated Resident #1's legs were contracted and a draw pad was needed to reposition her and reason why she always asked for assistance when providing her care. She stated she was a G-tube resident also and normally another staff was needed for ensure the tubing to stayed intact. She stated Resident #1 fell on [DATE] and she did not find out about it until Friday 08/09/24. Interview on 08/11/24 at 4:13 pm, LVN D stated she worked on 08/06/24 around 10:00 am and Resident #1 was not able to speak but could follow verbal commands. She stated on 08/06/24 she was giving her medications through her g-tube and Resident #1 was different and her mood was flat and she asked Resident #1 was she good and she did not nod her head yes like she usually did and she was not her normal self. She stated when she flipped her blanket back, she noticed her knee looked different, both of her legs were contracted, but the lower part of her left knee was swollen and purplish and when she moved her left leg, she pulled it back and guarded with it. She stated Resident #1 was not her regular self she saw the left knee was a little swollen with a little purplish bruise, from her knee to her ankle. She stated she took a picture and sent it to her Doctor because she took Eliquis and was not sure if she had a blood clot of not. She stated her Doctor ordered a doppler study then when she returned to work on 08/09/24 she found Resident #1 was transferred to the hospital because her leg was getting bigger. She stated 911 was called and they took her to the hospital. She stated Resident #1 was supposed to be on her bed for all care needs. She stated if a resident was on the floor mat due to having a guided fall was the same as a fall and the Doctor needed to be called immediately. She stated the Doctor needed to be called for special instructions on what to do, and the nurses were supposed to assess the resident and know the residents blood pressure and vitals and do neuro checks for 72 hours and complete an incident report. She stated Resident #1 was a 2 person assist Hoyer lift resident and 1 person assist for bed mobility and ADL care. She stated Resident #1 used a Geri chair because she could not use a regular chair because she had a stroke affecting her left side and was not able to sit up in a wheelchair. She stated Resident #1 was good following commands but could not speak but she could look at their face and body language for signs of pain. She stated monitoring checks and notifying the next nurse to follow up on the resident monitoring was also needed. She stated if a resident had a fall and it was not reported or documented the resident could get injured more or lose their life. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/12/24 at 12:53 pm, MDS Coordinator E, stated Resident #1's ADL status ranged and it depended on if she had any Muscle spasms related to her Multiple Sclerosis disease process. She stated Resident #1's status varied because on some days she was a little more rigid than other days. She stated it was reported on 08/02/24 Resident #1 had a change in position and was assisted to the floor, which was still considered a fall. She stated, 'Oh definitely' LVN B should have called Resident #1's Doctor on 08/02/24, because the Doctor may have wanted to order x-rays and do a follow up visit. She stated the nurses needed to ensure the residents did not have any post injuries at that moment and further down the road. Interview on 08/12/24 at 2:33 pm, Medical Director/Resident #1's Doctor stated he had not received a call from anyone on 08/02/24 or from LVN A about Resident #1 falling. He stated LVN B should have called him for Resident #1's change in condition and completed an incident/accident report. He stated the first question on the incident/accident report asked had the Doctor been notified. He stated the facility wanted the Doctor called for any falls with or without injury, because there could be some reason why the resident fell . He stated if they had a seizure or became dizzy that might qualify for more investigation. He stated the DON notified him on 08/09/24 of Resident #1's fall on 08/02/24 that LVN B found her on the floor and put her back to bed and did not report it to anyone. He stated Resident #1 was bed bound and needed total assist and he wondered how this could have happened. He stated if CNA A and LVN B would have reported Resident #1's fall, she could have been assessed sooner and a follow up visit done with a full investigation of what caused it. He stated Resident #1 could not roll or turnover and had no muscular tone and not able to speak. He stated he wondered how Resident #1 could have fallen out of bed if she was total assist. He stated a guided fall was the same as a fall. He stated after finding out about Resident #1's fall they have had an Ad hoc QAPI Meeting on 08/12/24, to discuss their plan to prevent this from happening again. He stated they started re-educating the staff with various in-service trainings and continue to review their plan and make changes as needed and continue to discuss in their QA meetings. Review of the Facility's Provider Investigation Report dated 08/08/24 revealed on 08/02/24 at 8:00 pm. Alleged Perpetrators: CNA A and LVN B denied the allegation and no witnesses: Assessment: On 08/08/24 at2:11 p.m.by ADON C, indicated Resident #1 was assessed for an injury of unknown origin: Resident lying in bed with head above bed elevated, alert, and able to respond to questions by nodding. Left lower leg swollen warm and painful to touch, venous doppler negative, x-rays confirmed proximal tibial and fibula fracture of left leg. No treatment, resident transferred to the hospital. Provider response: RP, DON Physician notified, X-rays confirmed fracture resident transported to Hospital, satisfaction survey completed, Skin assessment completed on other residents, In services on transfers, bed mobility and Hoyer lifts. In- services on abuse and neglect. Interviews with staff. CNA A and LVN B suspended pending Investigations. (continued on next page)

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Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Investigation Summary: On 8/2/24 in the PM. C.N.A. was providing incontinent care for Resident #1, Resident #1 rolled to the mat on the floor. C.N.A. notified LVN B. Nurse and C.N.A. assisted resident back to bed. No Documentation or Notification was given on 8/6/24 Nurse noted left leg swelling, Physician ordered a venous doppler. Doppler study had negative result. On 8/8/24 DR notified of doppler result and ordered x ray. X-rays confirmed proximal tibia and fibula shaft fracture. Administrator notified HHSC of injury of unknown origin Resident was transported to Hospital. In-services were started on Abuse, Neglect and Reporting, Transfer, Bed Mobility and Hoyer lifts. Event policy and notification. During interviews it was determined by CNA A, Resident #1 was picked up off the floor on 8/2/24. She stated that Nurse assisted her putting Resident #1 back to bed. LVN B confirmed that she assisted Resident #1 back to bed. LVN B and CNA A were suspended pending investigation. HHSC Investigator entered the building on 8/9/24 at 3:15 pm, HHSC reentered on 8/11/24 IJ was put in place at 5:30 pm. HHSC lowered the IJ 8/12/24 at 7:30 pm. Staff members LVN B and CNA A were terminated. Where others notified: Physician, RP, Ombudsman, Police, HHSC Facility investigation findings: Confirmed Provider action taken post investigation: HHSC onsite 8/09/24, 8/11/24, 8/12/24, Resident returned to facility 8/12/24, In-services on abuse neglect, reporting, Bed mobility and transfer, Events documentation and reporting to appropriate people with evidence based follow up. LVN B and CNA A were suspended and terminated. Record review of : Employee Statements dated 8/8/24, 8/9/24, Safe Survey Resident Interviews dated 8/9/24, Inservice trainings: Abuse and neglect definitions in-service dated 8/8/24, Check offs: Moving/positioning, assisting with dated 8/11/24, 8/12/24, Post Fall Physical Assessment Test dated 8/11/24, 8/12/24, Transfer training and bed mobility dated 8/9/24, Notification of change training dated 8/9/24, Employee Abuse investigation questionnaire dated 8/9/24, LVN B Employee Corrective Action Form suspended dated 8/9/24 and CNA A Employee Corrective Action Form suspended dated 8/9/24. [END] Record review of LVN B's Timesheet printed on 08/09/24 revealed she worked on: 08/02/24 5:45 pm - 7:40 am, 08/06/24 5:30 pm - 7:46 am, 08/07/24 5:26 pm - 7:51 am. Record review of an Article Tibia & Fibula Fracture (Broken Shinbone/Calf Bone) (clevelandclinic.org) last reviewed 06/01/23 revealed, Overview: What are tibia and fibula fractures? Tibia and fibula fractures are two broken bones in your lower leg. Your tibia is your shin bone. Your fibula is your calf bone. Because they're usually caused by major trauma like car accidents or falls, people often break both their tibia and fibula during the same injury. It's rare, but you can fracture one of your tibia or fibula without breaking the other. You might need surgery to repair your bones and physical therapy to regain your ability to move your leg. Record review of the facility's Change in condition policy revised 04/20/23 revealed, Policy statement: Our facility promptly notifies the resident, his or her attending physician, healthcare provider and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care .resident rights, etc.). Policy Interpretation and Implementation: 1. The nurse will notify the resident's attending physician, healthcare provider or physician on call when there has been a (an): a. accident or incident involving the resident . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy (IJ) was identified on 08/12/24 at 12:10 pm. The Administrator was notified and the IJ Template was provided to the Administrator on 08/12/24 at 12:10 pm. The following Plan of Removal was accepted on 08/12/24 at 4:45 p.m., revealed the following: Plan of Removal 580: Notify of Changes (Injury/Decline/Room Etc.)< [TRUNCATED]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews and record reviews, the facility failed to ensure the resident had the right to be free from neglect as defined in this subpart for one (Resident #1) of six residents reviewed for Neglect. CNA A failed to ensure Resident #1 did not fall out of bed on 08/02/24 while she was providing incontinent care and LVN B failed to document assessing Resident #1's fall, LVN B failed to notify Resident #1's Doctor, LVN B failed to complete an incident report, and LVN B failed to notify the oncoming Nurse, DON, and Administrator about Resident #1's fall. Subsequently, Resident #1 was sent to the hospital 08/08/24 and was diagnosed with two fractures Tibia (Shinbone) and Fibula (Calf bone) of her left lower leg. An Immediate Jeopardy (IJ) was identified on 08/11/24. An IJ Template was provided to the facility on [DATE] at 3:38 pm. While the Immediate Jeopardy was removed on 08/12/24 at 7:50 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place all residents at risk of having increased distress and pain resulting in a decline in their psycho-social well-being and health resulting in internal bleeding, more injuries from being moved or death. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old female who admitted [DATE] with a BIMS Staff Assessment score of 2 (Moderate impaired cognition), no speech, with a memory problem and severely impaired. She had upper extremity impairment on one side and lower extremity impairment of both sides. Her functioning abilities and goals: Self-care: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for all ADLs including (toileting, personal hygiene). Her functioning abilities and goals: Mobility: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for roll left and right and for chair/bed to chair transfer. She was always incontinent to bladder and bowel, has a progressive neurological conditions with diagnoses of hypertension. She had Multiple Sclerosis (nerve degeneration), Gastronomy status (feeding tube), Cardiac arrhythmia (arrhythmia (irregular heartbeat), dysphagia (not able to swallow properly), muscle weakness, atrial fibrillation (irregular heartbeat), and lack of coordination. She was 5'6 and 132 pounds. Record review of Resident #1's August 2024 Order Summary Report revealed orders for: Eliquis (blood thinner) 5 mg, folic acid 1 mg. senna 8.6 mg. tramadol 50 mg. Enteral Feeding tube, Enteral stoma site care, NPO, Enteral formula pump administration. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan printed 8/10/24 revealed, Multiple sclerosis: assist with ADL and comfort measures as needed, Abdominal binder: to keep G-tube in place keep head and bed elevated. Geri-chair: make as comfortable as possible, falls (Resident has a history of falling related to mobility due to Multiple Sclerosis): place resident in a fall prevention program. Multiple sclerosis at risk for a decline in current ADLs and injuries due to increased injuries and assist with ADL's and comfort measures as needed. Cognitive loss/dementia: allow time for task and responses. Communication has aphasia approach in calm manner. Falls - keep call light within reach, ADL Functional status: ambulation/transfers amount of assist: total x 2 non-ambulatory, bathing/hygiene assist: total x1, resident care as per policy, toileting amount of assist total x1. Record review of Resident #1's Progress notes reviewed from 08/02/24 to 08/09/24 did not reveal she had any falls or incidents. Record review on Resident #1's Plan of care (POC) report dated 08/02/2024 at 7:06 pm revealed, CNA A provided Incontinent care. Record review of Resident #1 X-Ray results dated 08/08/24 at 8:03 pm revealed, Clinical information: Bruising, swelling, Test procedures: Left tibia and fibula, two views. Findings: Proximal tibial and fibular shafts fracture. No osteolytic or osteosclerotic lesions. No signs of bone infection. Impression:1. Proximal tibial and fibular shafts fracture. 2. CT is recommended. Record review of Resident #1's Hospital Emergency Department Doctor's note dated 08/08/24 revealed, Chief complaint: Leg deformity: patient here from [Nursing Facility]. Left leg swelling noted and ecchymosis found this morning. On Eliquis .Patient is bed bound and nonverbal. Radiology: Tibia/fibula, left 2 views final result: Impression: Proximal left tibial and fibular fractures, negative left ankle and knee joint. Soft tissue swelling. Osteopenia. Record review of Resident #1's Incident/Accident Report completed date 08/09/24 at 6:08 pm by LVN B revealed, Event date 08/02/24 at 5:57 pm, in resident room, yes fall was witnessed, no injury and no pain, ROM without pain/limitations, no rotation/deformity/shortening noted .notifications: Attending physician faxed: no, Physician notified: no, Resident Representative notified: no, care plan reviewed: no. Record review of Resident #1's Progress note 08/02/2024 [Recorded as Late Entry on 08/09/2024 06:19 PM] by LVN B revealed, Events - fall: 11:06PM On 2nd of August, CNA call attention to this nurse to room XXXX and reported to this nurse that she rolled resident down to the floor mat while giving care. Observed and assess resident on the floor mat., no apparent injury noted at that time. No S/S of pain noted at that time. Resident was helped back to bed with the help of the CNA. Record review of Resident #1's Hospital Orthopedic Doctor note dated 08/09/24 revealed, Orthopedic diagnosis: Left Proximal tibia fracture. Orthopedic plan: Closed management of left proximal tibial fracture, knee immobilization, non-weight bearing. History of present illness: A [AGE] year-old female with multiple advance medical issues including MS, who is nonverbal at baseline .The patient is nonverbal, non-ambulatory. I do not think she would be a very good candidate for surgical intervention. I will plan for a knee immobilization and follow-up in the outpatient setting. Observation on 08/09/24 at 3:40 pm, Resident #1's room revealed a thin blue floormat that was approximately two inches in height and six feet in length on the left side of Resident #1's bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 08/10/24 at 3:37 pm, Resident #1 was at the hospital lying flat on her back, in bed watching Television, she nodded yes to her name. She shook her head no she was not hurting. When asked had she fallen out of bed, she looked at her left leg and did not shake or nod her head. There was a G-tube next to her bed she and she did not appear to be in pain. Her left leg was bent at a 45-degree angle with a knee immobilizer on it. Interview on 08/09/24 at 6:43 pm, CNA A stated on 08/02/24 after dinner she checked Resident #1 and incontinent care was needed. She stated she was standing right in front of the window with the bed elevated and while caring for Resident #1, she turned her towards the door then towards her. She stated she put the bed linen on the floor then rolled her to the right to clean her and afterwards she tried to grab her bed sheets at the foot of her bed. She stated then Resident #1 started shaking and rolled off the bed so she went to get LVN B who came to assess the resident and made sure she was okay. She stated she and LVN B got Resident #1 back to bed and got her dressed then LVN B asked her what happened and she told her she was doing incontinent care and the resident rolled to the floor. She stated Resident #1 was nonverbal but did not appear to be in any pain and her leg was not swollen or in a weird position. She stated she was not sure if the nurse called to have any x-rays done and did not see anyone come out to do x-rays during her shift. She stated there was most likely no x-rays done because the resident was not crying because she checked on her frequently and changed her about four more times that night. She stated typically they reported falls to the DON and from there the DON notified the Administrator. She stated she did not report this fall to the DON and Administrator because it was the weekend and the DON was not at the facility. She stated today 08/09/24 she came back to work and reviewed her assignment and did her walk through to get her eyes on the residents and noticed Resident #1 was not at the facility. She stated she asked Staffing Coordinator F what happened to Resident #1 and was told she went to the hospital with an injury unknown origin of her leg. She stated Staffing Coordinator F told her there was an investigation about Resident #1's injury and that she needed to talk to the Administrator. She stated on 08/09/24, she wrote up her statement and spoke to the DON about what happened on 08/02/24. She stated on 08/09/24 around 6:00 pm she was suspended and was told they would let her know more information later after they completed their investigation and would get back with her soon. She stated she did not ever want to step on anyone's toes when she told LVN B about what happened to Resident #1 and did not think to report it to the DON also. She stated in her eyes Resident #1 had a rollover onto the floor. She stated she received training today 08/09/24 on abuse and neglect and for if the resident's fall was guided, she was supposed to report it to their Administrator. She stated Resident #1 she believed was a 1 person assist for ADL care and for transfers was Hoyer 2 person assist. She stated she knew the resident's level of care by asking the nurse what the resident's transfer status and care needs were. She stated not being really sure on how to use the POC in the EMR system because when she clicked on that tab and it did not have the resident's mobility statuses in them. She stated the POC only had the resident's demographic info. She stated she should have reported this fall to the Administrator because there was a change in Resident #1's health. She stated if she would have reported it to the Administrator and DON, this whole situation would not have happened. She stated on Friday 08/02/24 she worked from 2:00 pm to 6:00 am then worked Sunday 08/04/24 from 2:00 pm - 6:00 am. She stated she also worked today 08/09/24 from 2:00 pm to 6:00 pm. She stated falls, including guided falls could cause death, injured bones, and internal bleeding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/10/24 at 9:09 am, LVN B stated she worked the overnight shift and last took care of Resident #1 Last Friday 08/02/24, Tuesday 08/06/24 and Wednesday 08/07/24. She stated yesterday 08/09/24 she heard Resident #1 had a leg fracture. She stated she was very surprised Resident #1 was injured. She stated the DON spoke to her about what she knew about Resident #1's fall on 08/02/24 then the DON told her she should have completed an incident report and called her Doctor. She stated she did a late add nurses note and incident/accident report on 08/09/24 per the DON's request. She stated last Friday 08/02/24 after meal service, after 11:00 pm she was at the nurses' station and CNA A stood at Resident #1's room door calling her name out loud about needing help putting Resident #1 back to bed. She stated she saw Resident #1 in her room and her bed was in the lowest position and Resident #1 was on the left side of her bed on the floor. She stated Resident #1 was on her back and her left leg was turned to the left, and her head and buttocks was flat on the floormat, she was on her back. She stated her left leg was paralyzed and for her care they normally used a pillow to prop it in place. She stated when Resident #1 was on the floor her Gtube port was okay and the tubing was still connected to the gtube pump. She stated there was no pillow under Resident #1's leg and the bed linen and pillow was on her bed. She stated she assessed Resident #1 and did not find anything wrong with her and she had no signs or symptoms of pain, then she and CNA A put her back to bed. She stated asking CNA A why Resident #1 on the floor and CNA A was said she rolled her onto the floor to give her incontinent care. She stated CNA A did not say Resident #1 fell but said she guided her to the floormat. She stated if CNA A told her Resident #1 had fallen, she would have reported it to her Doctor, the Administrator and DON. She stated she would have also documented it in Resident #1's nurses notes and completed an incident report and called her family. She stated she would have followed up with her to ensure she was fine and added Resident #1 was on scheduled Tramadol she received at 12:00 am and PRN Tylenol. She stated there was no increase in giving her more pain medications. She stated Resident #1's floor mat next was next to her bed 24/7 and Resident #1 normally did not get care on the floor mat that was why she questioned CNA A about it. She stated there was not anything propping her left leg, she checked on Resident #1 four or five times that night. She stated Resident #1 watched television and slept and she was given her Tramadol at midnight and she was asleep rest of the night. She stated she did not tell the oncoming nurse or the DON about her being on the floor because she got busy and did not suspect anything was wrong. She stated she got busy with taking care of other residents forgot to document at nurses note. She stated there was no swelling or redness of her legs during her 08/02/24 shift. She stated she returned to work Tuesday 08/06/24 the nurse reported Resident #1 had left leg swelling and her Doctor ordered for a doppler study for edema. She stated the doppler study result came back Wednesday 08/07/24 was negative and she faxed that result to her Doctor. She stated there were no new orders and she took a picture of Resident #1's left leg and sent it to her Doctor. She stated she got a call from the DON yesterday 08/09/24 around 4:00 pm and she returned the call around 4:49 pm and the DON told her to come to the facility. She stated a little after 5:00 pm she gave the DON her statement and completed Resident #1's incident report and completed in-service trainings on neglect/abuse, who was the abuse coordinator and the DON told her she should have reported this to her and called her Doctor and family. She stated she had the mind to call the DON but forgot and stated if a resident fell and the Doctor, DON or family was not notified could result in delayed injury. She stated that was why she always documented but she forgot to document Resident #1's fall and said after the DON spoke to her, she now knew why she should have completed a nurses note and reported it to her Doctor, DON, and family. She stated in general the residents were on the floor mat for care if they were uncooperative, but Resident #1 was never uncooperative and never on the floor for incontinent care. She stated she thought it was odd Resident #1 was on the floormat. She stated Resident #1 was a 1 person assist for incontinent care because she was not that heavy. heavy, but needed 2 person Hoyer assist for some care needs. She stated Resident #1 was bed bound with left sided weakness upper and lower and alert and oriented x1. She stated Resident #1 was not able to express her needs because she was aphasic and knew her name. She stated Resident #1 was able to gesture responses by nodding and shaking her head. She stated there was 1 nurse and 1 aide for on the norm for 21 residents. She stated she did not know Resident #1 was a 2 person assist for bed mobility but if a resident was skinny 1 person could do incontinent care on her. She stated only 1 CNA worked that side of the hall where Resident #1 was and CNA A never asked her for assistant with doing Resident #1's incontinent care. She

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 7:26 pm, the DON stated she received a report on 08/06/24 about Resident #1's left leg appearing shiny and red like she had irritated rash. She stated her Doctor ordered a doppler study of her left leg and the results came back negative. She stated the area on her leg started swelling up more and getting darker red and her Doctor diagnosed her with cellulitis and ordered antibiotics. She stated yesterday 08/08/24 her leg was still looking red and her Doctor ordered an X-ray and the result came back yesterday morning for two fractures of her left tibia and fibula. She stated they reported on 08/08/24 to HHSC of an injury of unknown origin because of the darkness of her leg that looked to be spreading to other areas of her leg. She stated she was just finding out today 08/09/24 around 4:30 pm Resident #1 fell Friday the night of 08/02/24. She stated there were no notes in her medical records and no incident reports. She stated Resident #1's fall should have been reported to her and the Administrator so they could have started investigating and reported this incident to HHSC. She stated had they had known sooner they would have reported this incident immediately. She stated they were currently doing in-service trainings with all staff, doing skin and pain assessment of all the residents. She stated they were doing a lot of trainings on abuse/neglect, notifications to the DON and Administrator. She stated the therapy staff were assisting with the trainings. She stated they were currently interviewing staff. She stated CNA A said she was doing Resident #1's incontinent care and when she turned to get some linen, Resident #1 rolled out of her bed. She stated CNA A told her that LVN B was alerted and Resident #1 was assessed but there was not any documentation of a nurses note, no notifications to her family, herself, or Administrator. She stated LVN B confirmed everything that happened she went into the room and the resident was on the floor, and CNA A explained she had guided the resident to the floor. She stated LVN B said she did a head-to-toe assessment and when asked why she did not document the assessment, LVN B said it got so busy and she forgot. The DON stated she informed Resident #1's Doctor today 08/09/24 about Resident #1's fall with injury and he was upset because no one had called him on 08/02/24. She stated the Doctor was at the facility visiting patients Monday 08/05/24 and no one told him about this. She stated ADON C assessed Resident #1 then she was transferred to the hospital. She stated she spoke to LVN B on 08/09/24 around 4:00 pm and she confirmed Resident #1 had fallen on 08/02/24. She stated LVN #1 was suspended. She stated she interviewed CNA A around 3:30 pm or 4:00 pm and CNA A was removed off the floor and interviewed with the Corporate Nurse Representative. She stated CNA A was sent to the conference room and until they received her statement. She stated she told CNA A she was suspended until they completed their investigation and sent her home. She stated LVN B came to the facility to drop off her statement and said she had not worked in the past two days. She stated the staff knew how to go into the EMR POC to review the resident's level of care and was not aware of any issues with that. She stated they were still investigating this incident and felt like the incident was not intentional and people just needed to think when they did resident care and thought about the processes beforehand. She stated from what she was told Resident #1's bed was at the level of CNA A's hips. She stated Resident #1 did have tremors and twitched a lot and said she was not sure if she was 1 or 2 person assist or Hoyer lift yet. She stated Resident #1 was not able to express her needs but was good at communicating by nodding and shaking her head. She stated Resident #1 required the use of a wheelchair and was not sure if she could move her legs but was in the process of finding out more. She stated unreported and undocumented falls could have adverse effects because neuro were checks needing to be done to monitor if they had a change of mental status, got injured and needed more pain medication and was a form of neglect. She stated Resident #1 had routine pain medication and since 08/02/24 she had not had any increased pain. She stated after Resident #1 fell her Doctor should have been called and the fact that CNA A said the resident fell off the bed, LVN B should have called her Doctor for further instructions. She stated the last she heard they were not going to do surgery to repair Resident #1's left tibia and fibula because of her MS diagnosis. (continued on next page)

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	675790	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 8:21 pm, the Administrator stated he found out Resident #1 fell on [DATE] and they were currently doing their investigation. He stated today 08/09/24 CNA A said Resident #1 fell last Friday 08/02/24 and that she and LVN B got her back into bed and they suspended her. He stated they called LVN B to tell them her story and she was interviewed then they decided to suspend LVN B pending investigation for not following their events protocol procedure. He stated they needed to ensure there was not anything missed and added up to the point they knew Resident #1 could not move and something was going on with her leg he reported this incident to HHSC. He stated yesterday 08/08/24 Resident #1 was transferred to the hospital after her x-ray result showed she had fibula and tibia fractures of her left leg. He stated ever since then they were doing employee trainings on abuse/neglect, resident transfer techniques, reporting events and change in condition. He stated the DON and ADON was responsible for ensuring the nursing staff were following their protocols. He stated they reviewed all of Resident #1's documentation today and there was not any documentation about her falling. He stated unreported and undocumented falls could cause all kinds of things could happen such as pain, worsening condition, tons of things, no follow up on the resident's status. He stated they spoke to the Medical Director about Resident #1's fall with injury and they planned to continue to do trainings and get statements from the staff. He stated they were reviewing her documents and other residents' documents to protect all the residents and to see if they could do something another way to communicate better. He stated Resident #1 was a 1 person ADL assist resident because she was able to assist with turning and a petite lady and it was easy to turn her one way from to the other. Interview on 08/10/24 at 11:00 a.m. with the Hospital RN stated Resident #1 admitted to the hospital because of a fractured tibia and fibula. She stated she was stable right now and was currently awake but nonverbal and just nodded in agreement to everything and was not good at following commands. She stated Resident #1 did not appear to be in any pain and no surgery was planned yet and they were doing conservative treatments on her. She stated there were no discharge plans at this time and her pain levels were fine but grimaced when providing care then but when still no signs or symptoms of pain. She stated she had not been given any pain medications since she admitted on [DATE] but had Doctor orders for Norco for moderate pain. She stated she Resident #1 has Doctor orders for Ativan for anxiety, morphine for severe pain and Tylenol for mild pain/headache. She stated Resident #1 had an immobilizer on her left leg and stated both her arms were contracted (right arm moved a little more and her left arm was more contracted). She stated her left leg was completed contracted and stated she was a 2 person assist because it was hard to turn her because she was very stiff. She stated Resident #1 was given 4 mg. of morphine on 8/8/24 at 10:15 pm in the ER via her G-tube. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/11/24 at 2:28 pm, ADON C stated last Tuesday 08/06/24 LVN D reported Resident #1 had redness of her left leg and her Doctor was called and he ordered for her to get a doppler study that came back negative. She stated on Thursday 08/08/24 LVN O reported something was going on with Resident #1's left leg was swollen and the color was reddish and greenish. She stated she assessed Resident #1's left leg and tried to move her leg but when she moved her leg back the resident flinched her leg back. She stated she asked her was she in pain and she moved head but it was not a distinct nod or shake. She stated she asked Resident #1 was her leg in pain and she gestured yes. She stated she was not crying or appeared to be in pain and noticed the upper part of chin had discoloration and swelling from under her kneecap to her lower leg. She stated she notified Resident #1's Doctor herself and he ordered doxycycline, x-ray and lab work and she contacted her FM. She stated when her x-ray results came back showing she had a fractured tibia and fractured fibula shaft, they sent her to the hospital. She stated Resident #1 was a Hoyer lift transfer resident and she was a 1-person physical assist for incontinent care/bed mobility. She stated Resident #1's legs were contracted and a draw pad was needed to reposition her and reason why she always asked for assistance when providing her care. She stated she was a G-tube resident also and normally another staff was needed for ensure the tubing to stayed intact. She stated Resident #1 fell on [DATE] and she did not find out about it until Friday 08/09/24. She stated Oh yes if a resident had a guided fall or an assisted fall is a fall and a change in the resident's level of positioning. She stated Resident #1 had never been uncooperative with ADL care, but her legs were contracted and left hand was contracted. She stated she had never seen Resident #1 getting incontinent care on the floor mat and there were no reports of such. Interview on 08/11/24 at 4:13 pm, LVN D stated she worked on 08/06/24 around 10:00 am and Resident #1 was not able to speak but could follow verbal commands. She stated on 08/06/24 she was giving her medications through her g-tube and Resident #1 was different and her mood was flat and she asked Resident #1 was she good and she did not nod her head yes like she usually did and she was not her normal self. She stated when she flipped her blanket back, she noticed her knee looked different, both of her legs were contracted, but the lower part of her left knee was swollen and purplish and when she moved her left leg, she pulled it back and guarded with it. She stated Resident #1 was not her regular self she saw the left knee was a little swollen with a little purplish bruise, from her knee to her ankle. She stated she took a picture and sent it to her Doctor because she took Eliquis and was not sure if she had a blood clot of not. She stated her Doctor ordered a doppler study then when she returned to work on 08/09/24 she found Resident #1 was transferred to the hospital because her leg was getting bigger. She stated 911 was called and they took her to the hospital. She stated Resident #1 has never been non-compliant with care and had not ever seen her getting ADL care on her floor mat. She stated Resident #1 was supposed to be on her bed for all care needs. She stated if a resident was on the floor mat due to having a guided fall was the same as a fall and the Doctor needed to be called immediately. She stated the Doctor needed to be called for special instructions on what to do, and the nurses were supposed to assess the resident and know the residents blood pressure and vitals and do neuro checks for 72 hours and complete an incident report. She stated Resident #1 was a 2 person assist Hoyer lift resident and 1 person assist for bed mobility and ADL care. She stated Resident #1 used a Geri chair because she could not use a regular chair because she had a stroke affecting her left side and was not able to sit up in a wheelchair. She stated Resident # was good following commands but could not speak but she could look at their face and body language for signs of pain. She stated monitoring checks and notifying the next nurse to follow up on the resident monitoring was also needed. She stated if a resident had a fall and it was not reported or documented the resident could get injured more or lose their life. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/12/24 at 12:53 pm, MDS Coordinator E, stated Resident #1's ADL status ranged and it depended on if she had any Muscle spasms related to her Multiple Sclerosis disease process. She stated Resident #1's status varied because on some days she was a little more rigid than other days. She stated Resident #1 was a 1 to 2 person assist for bed mobility and hygiene on the MDS Assessment and stated she believed her care plan had her as a 2 person assist for bed mobility. She stated she would have to review that and get back with the surveyor. She stated Resident #1 was no longer on hospice as of last month and stated the resident's MDS's should match what their Care Plans were. She stated Resident #1 was an extensive assist, Hoyer lift resident. She stated Resident #1 got out of bed rarely and when she did, they transferred her to a Geri-chair. She stated their interdisciplinary team updated the residents Care plans with an RN or DON verifying the information was accurate. She stated the Care plans showed each resident's proper level of care, detailed safety issues on how to care for the residents. She stated if the resident's care plans were inaccurate it could lead up to injury due to them not receiving the proper care. She stated the nurses and cna's used care plans to know how to take care of each of the residents and whatever data was on the resident's MDS Assessments were reflected on their care plans. She stated the DON was responsible for ensuring the Care Plans were accurate. She stated both of Resident #1's legs were both contracted. She stated she admitted with the leg contractures and was able to wiggle her legs with both of her legs bending at a 45-degree angle. She stated Resident #1 received most times received bed baths. She stated it was reported on 08/02/24 Resident #1 had a change in position and was assisted to the floor, which was still considered a fall. She stated, 'Oh definitely' LVN B should have called Resident #1's Doctor on 08/02/24, because the Doctor may have wanted to order x-rays and do a follow up visit. She stated the nurses needed to ensure the residents did not have any post injuries at t [TRUNCATED]

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews and record reviews, the facility failed to implement written policies and procedures that prohibit neglect for one (Resident #1) of six residents reviewed for Neglect. CNA A and LVN B failed to prevent neglect, such as ensuring Resident #1 received the necessary care and services to prevent harm and LVN B's failure to notify the oncoming Nurse, DON and Administrator about Resident #1's fall on 08/02/24. Subsequently Resident #1 sustained fractures of her Tibia (Shinbone) and Fibula (calf bone) of her left lower leg and was taken to the hospital on 08/08/24. An Immediate Jeopardy (IJ) was identified on 08/11/24. An IJ Template was provided to the facility on [DATE] at 3:38 pm. While the Immediate Jeopardy was removed on 08/12/24 at 7:50 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place all residents at risk of not being assessed and treated in a timely manner and appropriately, with Doctors interventions, which could result in a decline in their psycho-social well-being and health resulting in internal bleeding or death. Findings included: Record review of the facility's Abuse and Neglect policy dated 10/2023 revealed, Policy Statement: The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Policy Interpretation and Implementation: 1. The facility will develop and implement written policies and procedures that: a. Prohibit abuse, neglect, and exploitation of residents and misappropriation of resident property . VI. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective all other required agencies (e.g., law enforcement when applicable) within specified timeframes. CMS Definition of neglect: Neglect is the failure of a 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. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old female who admitted [DATE] with a BIMS Staff Assessment score of 2 (Moderate impaired cognition), no speech, with a memory problem and severely impaired. She had upper extremity impairment on one side and lower extremity impairment of both sides. Her functioning abilities and goals: Self-care: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for all ADLs including (toileting, personal hygiene). Her functioning abilities and goals: Mobility: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for roll left and right and for chair/bed to chair transfer. She was always incontinent to bladder and bowel, has a progressive neurological conditions with diagnoses of hypertension. She had Multiple Sclerosis (nerve degeneration), Gastronomy status (feeding tube), Cardiac arrhythmia (arrhythmia (irregular heartbeat), dysphagia (not able to swallow properly), muscle weakness, atrial fibrillation (irregular heartbeat), and lack of coordination. She was 5'6 and 132 pounds. Record review of Resident #1's August 2024 Order Summary Report revealed orders for: Eliquis 5 mg, folic acid 1 mg. senna 8.6 mg. tramadol 50 mg. Enteral Feeding tube, Enteral stoma site care, NPO, Enteral formula pump administration. Record review of Resident #1's Care Plan printed 8/10/24 revealed, Multiple sclerosis: assist with ADL and comfort measures as needed, Abdominal binder: to keep G-tube in place keep head and bed elevated. Geri-chair: make as comfortable as possible, falls (Resident has a history of falling related to mobility due to Multiple Sclerosis): place resident in a fall prevention program. Multiple sclerosis at risk for a decline in current ADLs and injuries due to increased injuries and assist with ADL's and comfort measures as needed. Cognitive loss/dementia: allow time for task and responses. Communication has aphasia approach in calm manner. Falls - keep call light within reach, ADL Functional status: ambulation/transfers amount of assist: total x 2 non-ambulatory, bathing/hygiene assist: total x1, resident care as per policy, toileting amount of assist total x1. Record review of Resident #1's Progress notes reviewed from 08/02/24 to 08/09/24 did not reveal she had any falls or incidents. Record review of Resident #1 X-Ray results dated 08/08/24 at 8:03 pm revealed, Clinical information: Bruising, swelling, Test procedures: Left tibia and fibula, two views. Findings: Proximal tibial and fibular shafts fracture. No osteolytic or osteosclerotic lesions. No signs of bone infection. Impression:1. Proximal tibial and fibular shafts fracture. 2. CT is recommended. Record review of Resident #1's Hospital Emergency Department Doctor's note dated 08/08/24 revealed, Chief complaint: Leg deformity: patient here from [Nursing Facility]. Left leg swelling noted and ecchymosis found this morning. On Eliquis .Patient is bed bound and nonverbal. Radiology: Tibia/fibula, left 2 views final result: Impression: Proximal left tibial and fibular fractures, negative left ankle and knee joint. Soft tissue swelling. Osteopenia. Record review of Resident #1's Progress note 08/02/2024 [Recorded as Late Entry on 08/09/2024 06:19 PM] by LVN B revealed, Events - fall: 11:06PM On 2nd of August, CNA call attention to this nurse to room [ROOM NUMBER]B and reported to this nurse that she rolled resident down to the floor mat while giving care. Observed and assess resident on the floor mat., no apparent injury noted at that time. No S/S of pain noted at that time. Resident was helped back to bed with the help of the CNA. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Incident/Accident Report completed date 08/09/24 at 6:08 pm by LVN B revealed, Event date 08/02/24 at 5:57 pm, in resident room, yes fall was witnessed, no injury and no pain, ROM without pain/limitations, no rotation/deformity/shortening noted .notifications: Attending physician faxed: no, Physician notified: no, Resident Representative notified: no, care plan reviewed: no. Record review of Resident #1's Hospital Orthopedic Doctor note dated 08/09/24 revealed, Orthopedic diagnosis: Left Proximal tibia fracture. Orthopedic plan: Closed management of left proximal tibial fracture, knee immobilization, non-weight bearing. History of present illness: A [AGE] year-old female with multiple advance medical issues including MS, who is nonverbal at baseline .The patient is nonverbal, non-ambulatory. I do not think she would be a very good candidate for surgical intervention. I will plan for a knee immobilization and follow-up in the outpatient setting. Observation on 08/09/24 at 3:40 pm, Resident #1's room revealed a thin blue floormat that was approximately two inches height and six feet in length on the left side of Resident #1's bed. Observation on 08/10/24 at 3:37 pm, Resident #1 was at the hospital lying flat on her back, in bed watching Television, she nodded yes to her name. She shook her head no she was not hurting. When asked had she fallen out of bed, she looked at her left leg and did not shake or nod her head. There was a G-tube next to her bed she and she did not appear to be in pain. Her left leg was bent at a 45-degree angle with a knee immobilizer on it. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 6:43 pm, CNA A stated on 08/02/24 after dinner she checked Resident #1 and incontinent care was needed. She stated she was standing right in front of the window with the bed elevated and while caring for Resident #1, she turned her towards the door then towards her. She stated she put the bed linen on the floor then rolled her to the right to clean her and afterwards she tried to grab her bed sheets at the foot of her bed. She stated then Resident #1 started shaking and rolled off the bed so she went to get LVN B who came to assess the resident and made sure she was okay. She stated she and LVN B got Resident #1 back to bed and got her dressed then LVN B asked her what happened and she told her she was doing incontinent care and the resident rolled to the floor. She stated Resident #1 was nonverbal but did not appear to be in any pain and her leg was not swollen or in a weird position. She stated she was not sure if the nurse called to have any x-rays done and did not see anyone come out to do x-rays during her shift. She stated there was most likely no x-rays done because the resident was not crying because she checked on her frequently and changed her about four more times that night. She stated typically they reported falls to the DON and from there the DON notified the Administrator. She stated she did not report this fall to the DON and Administrator because it was the weekend and the DON was not at the facility. She stated today 08/09/24 she came back to work and reviewed her assignment and did her walk through to get her eyes on the residents and noticed Resident #1 was not at the facility. She stated she asked Staffing Coordinator F what happened to Resident #1 and was told she went to the hospital with an injury unknown origin of her leg. She stated Staffing Coordinator F told her there was an investigation about Resident #1's injury and that she needed to talk to the Administrator. She stated on 08/09/24, she wrote up her statement and spoke to the DON about what happened on 08/02/24. She stated on 08/09/24 around 6:00 pm she was suspended and was told they would let her know more information later after they completed their investigation and would get back with her soon. She stated she did not ever want to step on anyone's toes when she told LVN B about what happened to Resident #1 and did not think to report it to the DON also. She stated in her eyes Resident #1 had a rollover onto the floor. She stated she received training today 08/09/24 on abuse and neglect and for if the resident's fall was guided, she was supposed to report it to their Administrator. She stated Resident #1 she believed was a 1 person assist for ADL care and for transfers was Hoyer 2 person assist. She stated she knew the resident's level of care by asking the nurse what the resident's transfer status and care needs were. She stated not being really sure on how to use the POC in the EMR system because when she clicked on that tab it did not have the resident's mobility statuses in them. She stated the POC only had the resident's demographic info. She stated she should have reported this fall to the Administrator because there was a change in Resident #1's health. She stated if she would have reported it to the Administrator and DON, this whole situation would not have happened. She stated on Friday 08/02/24 she worked from 2:00 pm to 6:00 am then worked Sunday 08/04/24 from 2:00 pm - 6:00 am. She stated she also worked today 08/09/24 from 2:00 pm to 6:00 pm. She stated falls, including guided falls could cause death, injured bones, and internal bleeding. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/10/24 at 9:09 am, LVN B stated she worked the overnight shift and last took care of Resident #1 Last Friday 08/02/24, Tuesday 08/06/24 and Wednesday 08/07/24. She stated yesterday 08/09/24 she heard Resident #1 had a leg fracture. She stated she was very surprised Resident #1 was injured. She stated the DON spoke to her about what she knew about Resident #1's fall on 08/02/24 then the DON told her she should have completed an incident report and called her Doctor. She stated she did a late add nurses note and incident/accident report on 08/09/24 per the DON's request. She stated last Friday 08/02/24 after meal service, after 11:00 pm she was at the nurses' station and CNA A stood at Resident #1's room door calling her name out loud about needing help putting Resident #1 back to bed. She stated she saw Resident #1 in her room and her bed was in the lowest position and Resident #1 was on the left side of her bed on the floor. She stated Resident #1 was on her back and her left leg was turned to the left, and her head and buttocks was flat on the floormat, she was on her back. She stated her left leg was paralyzed and for her care they normally used a pillow to prop it in place. She stated when Resident #1 was on the floor her Gtube port was okay and the tubing was still connected to the gtube pump. She stated there was no pillow under Resident #1's leg and the bed linen and pillow was on her bed. She stated she assessed Resident #1 and did not find anything wrong with her and she had no signs or symptoms of pain, then she and CNA A put her back to bed. She stated asking CNA A why Resident #1 on the floor and CNA A was said she rolled her onto the floor to give her incontinent care. She stated CNA A did not say Resident #1 fell but said she guided her to the floormat. She stated if CNA A told her Resident #1 had fallen, she would have reported it to her Doctor, the Administrator and DON. She stated she would have also documented it in Resident #1's nurses notes and completed an incident report and called her family. She stated she would have followed up with her to ensure she was fine and added Resident #1 was on scheduled Tramadol she received at 12:00 am and PRN Tylenol. She stated there was no increase in giving her more pain medications. She stated Resident #1's floor mat next was next to her bed 24/7 and Resident #1 normally did not get care on the floor mat that was why she questioned CNA A about it. She stated there was not anything propping her left leg, she checked on Resident #1 four or five times that night. She stated Resident #1 watched television and slept and she was given her Tramadol at midnight and she was asleep rest of the night. She stated she did not tell the oncoming nurse or the DON about her being on the floor because she got busy and did not suspect anything was wrong. She stated she got busy with taking care of other residents forgot to document at nurses note. She stated there was no swelling or redness of her legs during her 08/02/24 shift. She stated she returned to work Tuesday 08/06/24 the nurse reported Resident #1 had left leg swelling and her Doctor ordered for a doppler study for edema. She stated the doppler study result came back Wednesday 08/07/24 was negative and she faxed that result to her Doctor. She stated there were no new orders and she took a picture of Resident #1's left leg and sent it to her Doctor. She stated she got a call from the DON yesterday 08/09/24 around 4:00 pm and she returned the call around 4:49 pm and the DON told her to come to the facility. She stated a little after 5:00 pm she gave the DON her statement and completed Resident #1's incident report and completed in-service trainings on neglect/abuse, who was the abuse coordinator and the DON told her she should have reported this to her and called her Doctor and family. She stated she had the mind to call the DON but forgot and stated if a resident fell and the Doctor, DON or family was not notified could result in delayed injury. She stated that was why she always documented but she forgot to document Resident #1's fall and said after the DON spoke to her, she now knew why she should have completed a nurses note and reported it to her Doctor, DON, and family. She stated in general the residents were on the floor mat for care if they were uncooperative, but Resident #1 was never uncooperative and never on the floor for incontinent care. She stated she thought it was odd Resident #1 was on the floormat. She stated Resident #1 was a 1 person assist for incontinent care because she was not that heavy. heavy, but needed 2 person Hoyer assist for some care needs. She stated Resident #1 was bed bound with left sided weakness upper and lower and alert and oriented x1. She stated Resident #1 was not able to express her needs because she was aphasic and knew her name. She stated Resident #1 was able to gesture responses by nodding and shaking her head. She stated there was 1 nurse and 1 aide for on the norm for 21 residents. She stated she did not know Resident #1 was a 2 person assist for bed mobility but if a resident was skinny 1 person could do incontinent care on her. She stated only 1 CNA worked that side of the hall where Resident #1 was and CNA A never asked her for assistant with doing Resident #1's incontinent care. She

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	675790	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 4:45 pm, the Police Detective stated he visited Resident #1 at the hospital and gathered other information and opened a case to further investigate the circumstances involving Resident #1's leg injury. He stated he had spoken to CNA A who said on 08/02/24 she was cleaning Resident #1 and she turned around then the resident kept rolling and fell out of the bed. He stated CNA A said she asked LVN B to help get Resident #1 off of the floor then LVN B picked up Resident #1 and put her back onto her bed. The Police Detective stated as of right now there was no documentation of the resident falling and no one knew what happened to her leg and the resident was not able to say what happened. He stated the Administrator and DON said they just discovered it from CNA A's statement. He stated Resident #1 sustained two fractures of her left tibia and left fibula that was approximately one inch below her knee. He stated Resident #1's roommate said she remembered a nurse and CNA coming in really fast one night but was not able to see or know what happened. He stated he was getting ready to interview LVN B to gather more information. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 7:26 pm, the DON stated she received a report on 08/06/24 about Resident #1's left leg appearing shiny and red like she had irritated rash. She stated her Doctor ordered a doppler study of her left leg and the results came back negative. She stated the area on her leg started swelling up more and getting darker red and her Doctor diagnosed her with cellulitis and ordered antibiotics. She stated yesterday 08/08/24 her leg was still looking red and her Doctor ordered an X-ray and the result came back yesterday morning for two fractures of her left tibia and fibula. She stated they reported 08/08/24 to HHSC and an injury of unknown origin because of the darkness of her leg that looked to be spreading to other areas of her leg. She stated she was just finding out today 08/09/24 around 4:30 pm Resident #1 fell Friday night of 08/02/24. She stated there were no notes in her medical records and no incident reports. She stated Resident #1's fall should have been reported to her and the Administrator to they could have started investigating and reported this incident to HHSC. She stated had they had known soon they would have reported this incident immediately. She stated they were currently doing in-service trainings with all staff, doing skin and pain assessment of all the residents. She stated they were doing a lot of trainings on abuse/neglect, notification to the resident's Doctor, DON and Administrator and did 1:1 trainings with LVN B and now they were training all staff. She stated the therapy staff were assisting with the trainings. She stated it was too early in her investigation and was not sure if Resident #1 was a 1 or 2 person assist for ADL's but said she would follow-up with surveyor. She stated CNA A said she was doing Resident #1's incontinent care and when she turned to get some linen, Resident #1 rolled out of her bed. She stated CNA A told her that LVN B was alerted and Resident #1 was assessed but there was not any documentation of a nurses note, no notifications to her Doctor, family, herself, or Administrator. She stated LVN B confirmed everything that happened she went into the room the resident was on the floor, and CNA A explained she had guided the resident to the floor. She stated LVN B said she did a head-to-toe assessment and when asked why she not documented the assessment LVN B said it got so busy and she forgot. The DON stated she informed Resident #1's Doctor about Resident #1's fall with injury and he was upset because no one had called him 08/02/24. She stated the Doctor was at the facility visiting patients Monday 08/05/24 and no one told him about this until today 08/09/24 around 4:30 pm. She stated particularly concerning was CNA A said she noticed Resident #1's left leg was swollen on Sunday 08/04/24 and did not report it to anyone assuming the nurses were aware of it. She stated ADON C assessed Resident #1 then she was transferred to the hospital. She stated she spoke to LVN B on 08/09/24 around 4:00 pm she confirmed Resident #1 had fallen on 08/02/24. She stated LVN #1 was suspended. She stated she interviewed CNA A around 3:30 pm or 4:00 pm and CNA A was removed off the floor and interviewed with the Corporate Nurse Representative. She stated CNA A was sent to the conference room and until they received her statement. She stated she told CNA A she was suspended until they completed their investigation and sent her home. She stated LVN B came to the facility to drop off her statement and said she had not worked in the past two days. She stated the staff knew how to go into the EMR POC to review the resident's level of care and was not aware of any issues with that. She stated they were still investigating this incident and felt like the incident was not intentional and people just needed to think when they did resident care and thought about the processes beforehand. She stated from what she was told Resident #1's bed was at the level of CNA's hips. She stated Resident #1 did have tremors and twitched a lot and said she was not sure if she was 1 or 2 or Hoyer lift yet. She stated Resident #1 was not able to express her needs but was good at communicating by nodding and shaking her head. She stated Resident #1 required the use of a wheelchair and was not sure if she could move her legs but was in the process of finding out more. She stated unreported and undocumented falls could have adverse effects because neuro checks needed to be done to monitor if they have a change of mental status, get injured need more pain and was a form of neglect. She stated Resident #1 has routine pain medication and since 08/02/24 she had not had any increased pain. She stated after Resident #1 fell her Doctor should have been called and the fact that CNA A said the resident fell off the bed LVN B should have called her Doctor for further instructions. She stated the last she heard they were not going to do surgery to repair her left tibia and fibula because of her MS diagnosis. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 8:21 pm, the Administrator stated he found out Resident #1 fell [DATE] and they were currently doing their investigation. He stated today 08/09/24 CNA A said Resident #1 fell last Friday 08/02/24 and that she and LVN B got her back into bed and they suspended her. He stated they called LVN B to tell them her story and she was interviewed then they decided to suspend LVN B pending investigation for not following their events protocol procedure. He stated they needed to ensure there was not anything missed and added up to the point they knew Resident #1 could not move and something was going on with her leg so he reported this incident to HHSC. He stated yesterday 08/08/24 Resident #1 was transferred to the hospital after her x-ray result showed she had fibula and tibia fractures of her left leg. He stated ever since then they were doing employee trainings on abuse/neglect, resident transfer techniques, reporting events and change in condition. He stated the DON and ADON was responsible for ensuring the nursing staff were following their protocols. He stated they reviewed all of Resident #1's documentation today and there was not any documentation about her falling. He stated unreported and undocumented falls could cause all kinds of things could happen such as pain, worsening condition, tons of things, no follow up on the resident's status. He stated they spoke to the Medical Director about Resident #1's fall with injury and they planned to continue to do trainings, getting statements for the staff. He stated they were reviewing her documents and other residents to protect all the residents and to see if they could do something another way, communicate better. He stated Resident #1 was a 1 person ADL assist resident because she was able to assist with turning and a petite lady and it was easy to turn her one way from to the other. Interview on 08/10/24 at 11:00 am with the Hospital RN stated Resident #1 admitted to the hospital because of a fractured tibia and fibula. She stated she was stable right now and was currently awake but nonverbal and just nodded in agreement to everything and was not good at following commands. She stated Resident #1 did not appear to be in any pain and no surgery was planned yet and they were doing conservative treatments on her. She stated there were no discharge plans at this time and her pain levels were fine but grimaced when providing care then but when still no signs or symptoms of pain. She stated she had not been given any pain medications since she admitted on [DATE] but had Doctor orders for Norco for moderate pain. She stated she Resident #1 has Doctor orders for Ativan for anxiety, morphine for severe pain and Tylenol for mild pain/headache. She stated Resident #1 had an immobilizer on her left leg and stated both her arms were contracted (right arm moved a little more and her left arm was more contracted). She stated her left leg was completed contracted and stated she was a 2 person assist because it was hard to turn her because she was very stiff. She stated Resident #1 was given 4 mg. of morphine on 8/8/24 at 10:15 pm in the ER via her G-tube. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/11/24 at 2:28 pm, ADON C stated last Tuesday 08/06/24 LVN D reported Resident #1 had redness of her left leg and her Doctor was called and he ordered for her to get a doppler study that came back negative. She stated on Thursday 08/08/24 LVN O reported something was going on with Resident #1's left leg was swollen and the color was reddish and greenish. She stated she assessed Resident #1's left leg and tried to move her leg but when she moved her leg back the resident flinched her leg back. She stated she asked her was she in pain and she moved head but it was not a distinct nod or shake. She stated she asked Resident #1 was her leg in pain and she gestured yes. She stated she was not crying or appeared to be in pain and noticed the upper part of chin had discoloration and swelling from under her kneecap to her lower leg. She stated she notified Resident #1's Doctor herself and he ordered doxycycline, x-ray and lab work and she contacted her FM. She stated when her x-ray results came back showing she had a fractured tibia and fractured fibula shaft, they sent her to the hospital. She stated Resident #1 was a Hoyer lift transfer resident and she was a 1-person physical assist for incontinent care/bed mobility. She stated Resident #1's legs were contracted and a draw pad was needed to reposition her and reason why she always asked for assistance when providing her care. She stated she was a G-tube resident also and normally another staff was needed for ensure the tubing to stayed intact. She stated Resident #1 fell on [DATE] and she did not find out about it until Friday 08/09/24. She stated Oh yes if a resident had a guided fall or an assisted fall is a fall and a change in the resident's level of positioning. She stated Resident #1 had never been uncooperative with ADL care, but her legs were contracted and left hand was contracted. She stated she had never seen Resident #1 getting incontinent care on the floor mat and there were no reports of such. Interview on 08/11/24 at 4:13 pm, LVN D stated she worked on 08/06/24 around 10:00 am and Resident #1 was not able to speak but could follow verbal commands. She stated on 08/06/24 she was giving her medications through her g-tube and Resident #1 was different and her mood was flat and she asked Resident #1 was she good and she did not nod her head yes like she usually did and she was not her normal self. She stated when she flipped her blanket back, she noticed her knee looked different, both of her legs were contracted, but the lower part of her left knee was swollen and purplish and when she moved her left leg, she pulled it back and guarded with it. She stated Resident #1 was not her regular self she saw the left knee was a little swollen with a little purplish bruise, from her knee to her ankle. She stated she took a picture and sent it to her Doctor because she took Eliquis and was not sure if she had a blood clot of not. She stated her Doctor ordered a doppler study then when she returned to work on 08/09/24 she found Resident #1 was transferred to the hospital because her leg was getting bigger. She stated 911 was called and they took her to the hospital. She stated Resident #1 has never been non-compliant with care and had not ever seen her getting ADL care on her floor mat. She stated Resident #1 was supposed to be on her bed for all care needs. She stated if a resident was on the floor mat due to having a guided fall was the same as a fall and the Doctor needed to be called immediately. She stated the Doctor needed to be called for special instructions on what to do, and the nurses were supposed to assess the resident and know the residents blood pressure and vitals and do neuro checks for 72 hours and complete an incident report. She stated Resident #1 was a 2 person assist Hoyer lift resident and 1 person assist for bed mobility and ADL care. She stated Resident #1 used a Geri chair because she could not use a regular chair because she had a stroke affecting her left side and was not able to sit up in a wheelchair. She stated Resident #1 was good following commands but could not speak but she could look at their face and body language for signs of pain. She stated monitoring checks and notifying the next nurse to follow up on the resident monitoring was also needed. She stated if a resident had a fall and it was not reported or documented the resident could get injured more or lose their life. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/12/24 at 12:53 pm, MDS Coordinator E, stated Resident #1's ADL status ranged and it depended on if she had any Muscle spasms related to her Multiple Sclerosis disease process. She stated Resident #1's status varied because on some days she was a little more rigid than other days. She stated Resident #1 was a 1 to 2 person assist for bed mobility and hygiene on the MDS Assessment and stated she believed her care plan had her as a 2 person assist for bed mobility. She stated she would have to review that and get back with the surveyor. She stated Resident #1 was no longer on hospice as of last month and stated the resident's MDS's should match what their Care Plans were. She stated Resident #1 was an extensive assist, Hoyer lift resident. She stated both of Resident #1's legs were both contracted. She stated she admitted with the leg contractures and was able to wiggle her legs with both of her legs bending at a 45-degree angle. She stated Resident #1 received most times received be [TRUNCATED]

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interviews, and record review, the facility failed to review and revise each assessment, including comprehensive and quarterly review assessments by the interdisciplinary team for one (Resident #1) of six residents reviewed for care plans. The facility failed to ensure Resident #1's care plan was revised after her MDS Assessment reflected she was Dependent; 2 person assist for Bed mobility and incontinent care. This failure could place the resident at risk of their current individual needs not being met, causing falls, which could result in a decline in their health and psycho-social well-being. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old female who admitted [DATE] with a BIMS Staff Assessment score of 2 (Moderate impaired cognition), no speech, with a memory problem and severely impaired. She had upper extremity impairment on one side and lower extremity impairment of both sides. Her functioning abilities and goals: Self-care: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for all ADLs including (toileting, personal hygiene). Her functioning abilities and goals: Mobility: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for roll left and right and for chair/bed to chair transfer. She was always incontinent to bladder and bowel, has a progressive neurological conditions with diagnoses of hypertension. She had Multiple Sclerosis (nerve degeneration), Gastronomy status (feeding tube), Cardiac arrhythmia (arrhythmia (irregular heartbeat), dysphagia (not able to swallow properly), muscle weakness, atrial fibrillation (irregular heartbeat), and lack of coordination. She was 5'6 and 132 pounds. Record review of Resident #1's Care Plan printed 8/10/24 revealed, Multiple sclerosis: assist with ADL and comfort measures as needed, Abdominal binder: to keep G-tube in place keep head and bed elevated. Geri-chair: make as comfortable as possible, falls (Resident has a history of falling related to mobility due to Multiple Sclerosis): place resident in a fall prevention program. Multiple sclerosis at risk for a decline in current ADLs and injuries due to increased injuries and assist with ADL's and comfort measures as needed. Cognitive loss/dementia: allow time for task and responses. Communication has aphasia approach in calm manner. Falls - keep call light within reach, ADL Functional status: ambulation/transfers amount of assist: total x 2 non-ambulatory, bathing/hygiene assist: total x1, resident care as per policy, toileting amount of assist total x1. Interview on 08/11/24 at 1:45 pm, the DON stated Resident #1 was a 1 person assist for incontinent care but her 07/05/24 MDS Assessment showed she was an extensive 2 person assist. She stated from what she knew, MDS Assessment should match the care plans. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/11/24 at 4:13 pm, LVN D stated Resident #1 was a 2 person assist Hoyer lift resident and 1 person assist for bed mobility and ADL care. She stated Resident #1 used a Geri chair because she could not use a regular chair because she had a stroke affecting her left side and was not able to sit up in a wheelchair. Interview on 08/12/24 at 12:53 pm, MDS Coordinator E, stated Resident #1's ADL status ranged and it depended on if she had any Muscle spasms related to her Multiple Sclerosis disease process. She stated Resident #1's status varied because on some days she was a little more rigid than other days. She stated Resident #1 was a 1 to 2 person assist for bed mobility and hygiene on the MDS Assessment and stated she believed her care plan had her as a 2 person assist for bed mobility. She stated she would have to review that and get back with the surveyor. She stated Resident #1 MDS's should match what their Care Plans were. She stated Resident #1 was an extensive assist, Hoyer lift resident. She stated Resident #1 got out of bed rarely and when she did, they transferred her to a Geri-chair. She stated their interdisciplinary team updated the residents Care plans with an RN or DON verifying the information was accurate. She stated the Care plans showed each resident's proper level of care, detailed safety issues on how to care for the residents. She stated if the resident's care plans were inaccurate it could lead up to injury due to them not receiving the proper care. She stated the nurses and cna's used care plans to know how to take care of each of the residents and whatever data was on the resident's MDS Assessments were reflected on their care plans. She stated the DON was responsible for ensuring the Care Plans were accurate. She stated both of Resident #1's legs were both contracted. She stated she admitted with the leg contractures and was able to wiggle her legs with both of her legs bending at a 45-degree angle. She stated Resident #1 did have limited range of motion, with bilateral upper and lower weakness. She stated Resident #1's MDS for bed mobility and hygiene was coded she was totally dependent with 2 person assist. She stated she was not aware Resident #1's Care Plans for bed mobility and hygiene showed she was 1 person assist. She stated she stated she would review all of the residents MDS's and Care plans to ensure the MDS Assessments and Care Plans matched. She stated they needed to change Resident #1's Care plan to show she's 2 person assist for bed mobility and incontinent care. Interview on 08/12/24 at 2:33 pm, the Medical Director/Resident #1's Doctor stated she had progressive MS. He stated Resident #1 was bed bound and needed total assist and could not roll or turnover and had no muscle tone. Interview on 08/12/24 at 7:00 pm, the DON Stated she was not aware of any issues with the care plans not being accurate. She stated the MDS Coordinator was responsible to ensure the care plans were accurate. She stated the POC came directly from the care plan that came from the MDS Assessment. She stated she would get with the MDS Coordinator to address this matter. Interview on 08/12/24 at 7:14 pm, the Administrator stated he was not aware that the care plans were not accurate. He stated the DON was responsible for ensuring the care plans policy was followed and would talk to the nursing department about getting them corrected. Record review of the Facility's Care Plan policy dated 01/26/24 revealed, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the resident's comprehensive assessment. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observations, interviews, and record reviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of six residents reviewed for Quality of Care. CNA A failed to provide incontinent care with a second staff member assisting, which resulted in Resident #1 falling out of bed. And LVN B failed to notify Resident #1's Doctor on 08/02/24 after CNA reported Resident #1 on the floor and assisted with getting Resident #1 on the floor. LVN B did not complete and document doing a head to toe assessment and incident report and did not monitor the resident or do neuro checks and notify other nursing staff to continue monitoring the resident. Subsequently, Resident #1 was sent to the hospital on 08/08/24 and was currently at the hospital diagnosed with two fractures, a Tibia (Shinbone) and Fibula (Calf bone) of her left lower leg. After administrative review, an IJ was identified on 08/28/24. The Administrator was notified and an IJ template was provided on 08/28/24 at 12:57 pm. While the IJ was removed on 08/12/24 at 7:50 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place all residents at risk of not being assessed and treated in a timely manner and appropriately, with Doctors interventions, which could result in a decline in their psycho-social well-being and health resulting in internal bleeding, pain when being moved causing further injury or death. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed, a [AGE] year-old female who admitted [DATE] with a BIMS Staff Assessment score of 2 (Moderate impaired cognition), no speech, with a memory problem and severely impaired. She had upper extremity impairment on one side and lower extremity impairment of both sides. Her functioning abilities and goals: Self-care: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for all ADLs including (toileting, personal hygiene). Her functioning abilities and goals: Mobility: Coded 01. Dependent helper does all of the effort, resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity for roll left and right and for chair/bed to chair transfer. She was always incontinent to bladder and bowel, has a progressive neurological conditions with diagnoses of hypertension. She had Multiple Sclerosis (nerve degeneration), Gastronomy status (feeding tube), Cardiac arrhythmia (irregular heartbeat), dysphagia (not able to swallow properly), muscle weakness, atrial fibrillation (irregular heartbeat), and lack of coordination. She was 5'6 and 132 pounds. Record review of Resident #1's August 2024 Order Summary Report revealed orders for: Eliquis (blood thinner) 5 mg, folic acid 1 mg. senna 8.6 mg. tramadol 50 mg. Enteral Feeding tube, Enteral stoma site care, NPO, Enteral formula pump administration. (continued on next page)

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	675790	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Care Plan printed 8/10/24 revealed, Multiple sclerosis: assist with ADL and comfort measures as needed, Abdominal binder: to keep G-tube in place keep head and bed elevated. Geri-chair: make as comfortable as possible, falls (Resident has a history of falling related to mobility due to Multiple Sclerosis): place resident in a fall prevention program. Multiple sclerosis at risk for a decline in current ADLs and injuries due to increased injuries and assist with ADL's and comfort measures as needed. Cognitive loss/dementia: allow time for task and responses. Communication has aphasia approach in calm manner. Falls - keep call light within reach, ADL Functional status: ambulation/transfers amount of assist: total x 2 non-ambulatory, bathing/hygiene assist: total x1, resident care as per policy, toileting amount of assist total x1. Record review of Resident #1's Progress notes reviewed from 08/02/24 to 08/09/24 did not reveal she had any falls or incidents. Record review of Resident #1's X-Ray results dated 08/08/24 at 8:03 p.m. revealed, Clinical information: Bruising, swelling, Test procedures: Left tibia and fibula, two views. Findings: Proximal tibial and fibular shafts fracture. No osteolytic or osteosclerotic lesions. No signs of bone infection. Impression:1. Proximal tibial and fibular shafts fracture. 2. CT is recommended. Record review of Resident #1's Hospital Emergency Department Doctor's note dated 08/08/24 revealed, Chief complaint: Leg deformity: patient here from [Nursing Facility]. Left leg swelling noted and ecchymosis found this morning. On Eliquis .Patient is bed bound and nonverbal. Radiology: Tibia/fibula, left 2 views final result: Impression: Proximal left tibial and fibular fractures, negative left ankle and knee joint. Soft tissue swelling. Osteopenia. Record review of Resident #1's Progress note 08/02/2024 [Recorded as Late Entry on 08/09/2024 06:19 PM] by LVN B revealed, Events - fall: 11:06 PM On 2nd of August, CNA call attention to this nurse to room XXXX and reported to this nurse that she rolled resident down to the floor mat while giving care. Observed and assess resident on the floor mat., no apparent injury noted at that time. No S/S of pain noted at that time. Resident was helped back to bed with the help of the CNA. Record review of Resident #1's Incident/Accident Report completed date 08/09/24 at 6:08 p.m. by LVN B revealed, Event date 08/02/24 at 5:57 p.m., in resident room, yes fall was witnessed, no injury and no pain, ROM without pain/limitations, no rotation/deformity/shortening noted .notifications: Attending physician faxed: no, Physician notified: no, Resident Representative notified: no, care plan reviewed: no. Record review of Resident #1's Hospital Orthopedic Doctor note dated 08/09/24 revealed, Orthopedic diagnosis: Left Proximal tibia fracture. Orthopedic plan: Closed management of left proximal tibial fracture, knee immobilization, non-weight bearing. History of present illness: A [AGE] year-old female with multiple advance medical issues including MS, who is nonverbal at baseline .The patient is nonverbal, non-ambulatory. I do not think she would be a very good candidate for surgical intervention. I will plan for a knee immobilization and follow-up in the outpatient setting. Observation on 08/09/24 at 3:40 p.m., Resident #1's room revealed a thin blue floormat that was approximately two inches height and six feet in length on the left side of Resident #1's bed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation on 08/10/24 at 3:37 p.m., Resident #1 was at the hospital lying flat on her back, in bed watching television, she nodded yes to her name. She shook her head no she was not hurting. When asked had she fallen out of bed, she looked at her left leg and did not shake or nod her head. There was a G-tube next to her bed and she did not appear to be in pain. And her left leg was bent at a 45-degree angle with a knee immobilizer on it. Interview on 08/09/24 at 6:43 p.m., CNA A stated on 08/02/24 after dinner she checked Resident #1 and incontinent care was needed. She stated she was standing right in front of the window with the bed elevated and while caring for Resident #1, she turned her towards the door then towards her. She stated she put the bed linen on the floor then rolled her to the right to clean her and afterwards she tried to grab her bed sheets at the foot of her bed. She stated then Resident #1 started shaking and rolled off the bed so she went to get LVN B who came to assess the resident and made sure she was okay. She stated she and LVN B got Resident #1 back to bed and got her dressed then LVN B asked her what happened and she told her she was doing incontinent care and the resident rolled to the floor. She stated Resident #1 was nonverbal but did not appear to be in any pain and her leg was not swollen or in a weird position. She stated she was not sure if the nurse called to have any x-rays done and did not see anyone come out to do x-rays during her shift. She stated there was most likely no x-rays done because the resident was not crying because she checked on her frequently and changed her about four more times that night. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/10/24 at 9:09 a.m., LVN B stated she worked the overnight shift and last took care of Resident #1 Last Friday 08/02/24, Tuesday 08/06/24 and Wednesday 08/07/24. She stated yesterday 08/09/24 she heard Resident #1 had a leg fracture. She stated she was very surprised Resident #1 was injured. She stated the DON spoke to her about what she knew about Resident #1's fall on 08/02/24 then the DON told her she should have completed an incident report and called her Doctor. She stated she did a late add nurses note and incident/accident report on 08/09/24 per the DON's request. She stated last Friday 08/02/24 after meal service, after 11:00 pm she was at the nurses' station and CNA A stood at Resident #1's room door calling her name out loud about needing help putting Resident #1 back to bed. She stated she saw Resident #1 in her room and her bed was in the lowest position and Resident #1 was on the left side of her bed on the floor. She stated Resident #1 was on her back and her left leg was turned to the left, and her head and buttocks was flat on the floormat, she was on her back. She stated her left leg was paralyzed and for her care they normally used a pillow to prop it in place. She stated when Resident #1 was on the floor her G-tube port was okay and the tubing was still connected to the g-tube pump. She stated there was no pillow under Resident #1's leg and the bed linen and pillow was on her bed. She stated she assessed Resident #1 and did not find anything wrong with her and she had no signs or symptoms of pain, then she CNA A put her back to bed. She stated when she asked CNA A why Resident #1 on the floor, CNA A said she rolled Resident #1 onto the floor to give her incontinent care. She stated CNA A did not say Resident #1 fell but said she guided her to the floormat. She stated if CNA A told her Resident #1 had fallen, she would have reported it to her Doctor. She stated she would have also documented it in Resident #1's nurses notes and completed an incident report and called her family. She stated she would have followed up with her to ensure she was fine and added Resident #1 was on scheduled Tramadol she received at 12:00 am and PRN Tylenol. She stated there was no increase in giving her more pain medications. She stated Resident #1's floor mat next was next to her bed 24/7 and Resident #1 normally did not get care on the floor mat that was why can questioned CNA A about it. She stated there was not anything propping her left leg, she checked on Resident #1 four or five times that night. She stated Resident #1 watched television and slept and she was given her Tramadol at midnight and she was asleep rest of the night. She stated she did not tell the oncoming nurse or the DON about her being on the floor because she got busy and did not suspect anything was wrong. She stated she got busy with taking care of other residents forgot to document at nurses note. She stated there was no swelling or redness of her legs during her 08/02/24 shift. She stated she returned to work Tuesday 08/06/24 the nurse reported Resident #1 had left leg swelling and her Doctor ordered for a doppler study for edema. She stated the doppler study result came back Wednesday 08/07/24 was negative and she faxed that result to her Doctor. She stated there were no new orders and she took a picture of Resident #1's left leg and sent it to her Doctor. She stated she got a call from the DON yesterday 08/09/24 around 4:00 pm and she returned the call around 4:49 pm and the DON told her to come to the facility. She stated a little after 5:00 pm she gave the DON her statement and completed Resident #1's incident report. The DON told her she should have reported this to her and called her Doctor and family. She stated she had the mind to call the DON but forgot and stated if a resident fell and the Doctor, DON or family was not notified could result in delayed injury. She stated that was why she always documented but she forgot to document Resident #1's fall and said after the DON spoke to her, she now knew why she should have completed a nurses note and reported it to her Doctor and family. She stated she thought it was odd Resident #1 was on the floormat. She stated Resident #1 was bed bound with left sided weakness, upper and lower and alert and oriented x1. She stated Resident #1 was not able to express her needs because she was aphasic and knew her name. She stated Resident #1 was able to gesture responses by nodding and shaking her head. She stated the nurses were responsible for ensuring the residents were getting proper care and cleaned and dry and checked every 2 hours. She stated the DON suspended her and CNA A pending the investigation of Resident #1. She stated not reporting something bad could cause the resident to get bruised, get skin tears or injured. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 4:45 p.m., The Police Detective stated he visited Resident #1 at the hospital and gathered other information and opened a case to further investigate the circumstances involving Resident #1's leg injury. He stated he had spoken to CNA A who said on 08/02/24 she was cleaning Resident #1 and she turned around then the resident kept rolling and fell out of the bed. He stated CNA A said she asked LVN B to help get Resident #1 off of the floor then LVN B picked up Resident #1 and put her back onto her bed. Police Detective stated as of right now there was no documentation of the resident falling and no one knew what happened to her leg and the resident was not able to say what happened. He stated the Administrator and DON said they just discovered it from CNA A's statement. He stated Resident #1 sustained two fractures of her left tibia and left fibula that was approximately one inch below her knee. He stated Resident #1's roommate said she remembered a nurse and CNA coming in really fast one night but was not able to see or know what happened. He stated he was getting ready to interview LVN B to gather more information. Interview on 08/09/24 at 7:26 p m, the DON stated she received a report on 08/06/24 about Resident #1's left leg appearing shiny and red like she had irritated rash. She stated her Doctor ordered a doppler study of her left leg and the results came back negative. She stated the area on her leg started swelling up more and getting darker red and her Doctor diagnosed her with cellulitis and ordered antibiotics. She stated yesterday 08/08/24 her leg was still looking red and her Doctor ordered an X-ray and the result came back yesterday morning for two fractures of her left tibia and fibula. She stated she was just finding out today 08/09/24 around 4:30 pm Resident #1 fell Friday night on 08/02/24. She stated there were no notes in her medical records and no incident reports. She stated they were currently doing in-service trainings with all staff and doing skin and pain assessments of all the residents. She stated the staff trainings were on notifications to the resident's Doctor and did 1:1 trainings with LVN B and now they were training all staff. She stated it was too early in her investigation and was not sure if Resident #1 was a 1 or 2 person assist for ADL's but said she would follow-up with the surveyor. She stated CNA A said she was doing Resident #1's incontinent care and when she turned to get some linen, Resident #1 rolled out of her bed. She stated CNA A told her that LVN B was alerted and Resident #1 was assessed but there was not any documentation of a nurses note and no notifications to her Doctor. She stated LVN B confirmed everything that happened she went into the room the resident was on the floor, and CNA A explained she had guided the resident to the floor. She stated LVN B said she did a head-to-toe assessment and when asked why she did not document the assessment LVN B said it got so busy and she forgot. The DON stated today 08/09/24 she informed Resident #1's Doctor about Resident #1's fall with injury and he was upset because no one had called him 08/02/24. She stated the Doctor was at the facility visiting patients Monday 08/05/24 and no one told him about this until today. She stated ADON C assessed Resident #1 then she was transferred to the hospital. She stated she spoke to LVN B on 08/09/24 around 4:00 pm she confirmed Resident #1 had fallen on 08/02/24. She stated LVN #1 was suspended. She stated LVN B came to the facility to drop off her statement and said she had not worked in the past two days. She stated Resident #1 was not able to express her needs but was good at communicating by nodding and shaking her head. She stated Resident #1 required the use a wheelchair and was not sure if she could move her legs but was in the process of finding out more. She stated unreported and undocumented falls could have adverse effects because neuro checks needed to be done to monitor if they had a change of mental status, got injured or needed more pain medications. She stated Resident #1 had routine pain medication and since 08/02/24 and she had not had any increased pain. She stated after Resident #1 fell her Doctor should have been called and the fact that CNA A said the resident fell off the bed, LVN B should have called her Doctor for further instructions. She stated the last she heard the hospital were not going to do surgery to repair her left tibia and fibula because of her MS diagnosis. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/09/24 at 8:21 p.m., the Administrator stated he found out Resident #1 fell [DATE] and they were currently doing their investigation. He stated today 08/09/24 CNA A said Resident #1 fell last Friday 08/02/24 and that she and LVN B got her back into bed and they suspended her. He stated they called LVN B to tell them her story and she was interviewed then they decided to suspend LVN B pending investigation for not following their events protocol procedure. He stated yesterday 08/08/24 Resident #1 was transferred to the hospital after her x-ray result showed she had fibula and tibia fractures of her left leg. He stated ever since then they were doing employee trainings on reporting events. He stated the DON and ADON were responsible for ensuring the nursing staff were following their protocols. He stated they reviewed all of Resident #1's documentation today and there was not any documentation about her falling. He stated unreported and undocumented falls could cause all kinds of things to happen such as pain, worsening condition, tons of things, no follow up on the resident's status. He stated they spoke to the Medical Director about Resident #1's fall with injury and they planned to continue to do trainings and get statements from the staff. He stated they were reviewing her documents and other residents to protect all the residents and to see if they could do something another way to communicate better. Interview on 08/10/24 at 11:00 a.m., with the Hospital RN stated Resident #1 admitted to the hospital because of a fractured tibia and fibula. She stated she was stable right now and was currently awake but nonverbal and just nodded in agreement to everything and was not good at following commands. She stated Resident #1 did not appear to be in any pain and no surgery was planned yet and they were doing conservative treatments on her. She stated there were no discharge plans at this time and her pain levels were fine but grimaced when providing care then but when still she had no signs or symptoms of pain. She stated she had not been given any pain medications since she admitted on [DATE] but had Doctor orders for Norco for moderate pain. She stated she Resident #1 has Doctor orders for Ativan for anxiety, morphine for severe pain and Tylenol for mild pain/headache. She stated Resident #1 had an immobilizer on her left leg and stated both her arms were contracted (right arm moved a little more and her left arm was more contracted). She stated her left leg was completed contracted and stated she was a 2 person assist because it was hard to turn her because she was very stiff. She stated Resident #1 was given 4 mg. of morphine on 8/8/24 at 10:15 pm in the ER via her G-tube. Interview on 08/11/24 at 1:45 p.m., the DON stated they updated the staff trainings that were conducted by herself and Nursing Supervisors RN G and LVN H. She stated they were reviewing the other resident's records to see if any other residents were affected no other residents were affected. She stated they started notification of changes trainings on 08/09/24. She stated she they started doing Resident's skin and pain assessments on Friday morning of 08/09/24. She stated LVN B said CNA A told her while giving Resident #1 incontinent care CNA A guide rolled the resident to the floor. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/11/24 at 2:28 pm, ADON C stated last Tuesday 08/06/24 LVN D reported Resident #1 had redness of her left leg and her Doctor was called and he ordered for her to get a doppler study that came back negative. She stated on Thursday 08/08/24 LVN O reported something was going on with Resident #1's left leg was swollen and the color was reddish and greenish. She stated she assessed Resident #1's left leg and tried to move her leg but when she moved her leg back the resident flinched her leg back. She stated she asked her was she in pain and she moved head but it was not a distinct nod or shake. She stated she asked Resident #1 was her leg in pain and she gestured yes. She stated she was not crying or appeared to be in pain and noticed the upper part of chin had discoloration and swelling from under her kneecap to her lower leg. She stated she notified Resident #1's Doctor herself and he ordered doxycycline, x-ray and lab work and she contacted her FM. She stated when her x-ray results came back showing she had a fractured tibia and fractured fibula shaft, they sent her to the hospital. She stated Resident #1 was a Hoyer lift transfer resident and she was a 1-person physical assist for incontinent care/bed mobility. She stated Resident #1's legs were contracted and a draw pad was needed to reposition her and reason why she always asked for assistance when providing her care. She stated she was a G-tube resident also and normally another staff was needed for ensure the tubing to stayed intact. She stated Resident #1 fell on [DATE] and she did not find out about it until Friday 08/09/24. Interview on 08/11/24 at 4:13 pm, LVN D stated she worked on 08/06/24 around 10:00 am and Resident #1 was not able to speak but could follow verbal commands. She stated on 08/06/24 she was giving her medications through her g-tube and Resident #1 was different and her mood was flat and she asked Resident #1 was she good and she did not nod her head yes like she usually did and she was not her normal self. She stated when she flipped her blanket back, she noticed her knee looked different, both of her legs were contracted, but the lower part of her left knee was swollen and purplish and when she moved her left leg, she pulled it back and guarded with it. She stated Resident #1 was not her regular self she saw the left knee was a little swollen with a little purplish bruise, from her knee to her ankle. She stated she took a picture and sent it to her Doctor because she took Eliquis and was not sure if she had a blood clot of not. She stated her Doctor ordered a doppler study then when she returned to work on 08/09/24 she found Resident #1 was transferred to the hospital because her leg was getting bigger. She stated 911 was called and they took her to the hospital. She stated Resident #1 was supposed to be on her bed for all care needs. She stated if a resident was on the floor mat due to having a guided fall was the same as a fall and the Doctor needed to be called immediately. She stated the Doctor needed to be called for special instructions on what to do, and the nurses were supposed to assess the resident and know the residents blood pressure and vitals and do neuro checks for 72 hours and complete an incident report. She stated Resident #1 was a 2 person assist Hoyer lift resident and 1 person assist for bed mobility and ADL care. She stated Resident #1 used a Geri chair because she could not use a regular chair because she had a stroke affecting her left side and was not able to sit up in a wheelchair. She stated Resident #1 was good following commands but could not speak but she could look at their face and body language for signs of pain. She stated monitoring checks and notifying the next nurse to follow up on the resident monitoring was also needed. She stated if a resident had a fall and it was not reported or documented the resident could get injured more or lose their life. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 08/12/24 at 12:53 pm, MDS Coordinator E, stated Resident #1's ADL status ranged and it depended on if she had any Muscle spasms related to her Multiple Sclerosis disease process. She stated Resident #1's status varied because on some days she was a little more rigid than other days. She stated it was reported on 08/02/24 Resident #1 had a change in position and was assisted to the floor, which was still considered a fall. She stated, 'Oh definitely' LVN B should have called Resident #1's Doctor on 08/02/24, because the Doctor may have wanted to order x-rays and do a follow up visit. She stated the nurses needed to ensure the residents did not have any post injuries at that moment and further down the road. Interview on 08/12/24 at 2:33 pm, Medical Director/Resident #1's Doctor stated he had not received a call from anyone on 08/02/24 or from LVN A about Resident #1 falling. He stated LVN B should have called him for Resident #1's change in condition and completed an incident/accident report. He stated the first question on the incident/accident report asked had the Doctor been notified. He stated the facility wanted the Doctor called for any falls with or without injury, because there could be some reason why the resident fell . He stated if they had a seizure or became dizzy that might qualify for more investigation. He stated the DON notified him on 08/09/24 of Resident #1's fall on 08/02/24 that LVN B found her on the floor and put her back to bed and did not report it to anyone. He stated Resident #1 was bed bound and needed total assist and he wondered how this could have happened. He stated if CNA A and LVN B would have reported Resident #1's fall, she could have been assessed sooner and a follow up visit done with a full investigation of what caused it. He stated Resident #1 could not roll or turnover and had no muscular tone and not able to speak. He stated he wondered how Resident #1 could have fallen out of bed if she was total assist. He stated a guided fall was the same as a fall. He stated after finding out about Resident #1's fall they have had an Ad hoc QAPI Meeting on 08/12/24, to discuss their plan to prevent this from happening again. He stated they started re-educating the staff with various in-service trainings and continue to review their plan and make changes as needed and continue to discuss in their QA meetings. Review of the Facility's Provider Investigation Report dated 08/08/24 revealed on 08/02/24 at 8:00 pm. Alleged Perpetrators: CNA A and LVN B denied the allegation and no witnesses: Assessment: On 08/08/24 at2:11 p.m.by ADON C, indicated Resident #1 was assessed for an injury of unknown origin: Resident lying in bed with head above bed elevated, alert, and able to respond to questions by nodding. Left lower leg swollen warm and painful to touch, venous doppler negative, x-rays confirmed proximal tibial and fibula fracture of left leg. No treatment, resident transferred to the hospital. Provider response: RP, DON Physician notified, X-rays confirmed fracture resident transported to Hospital, satisfaction survey completed, Skin assessment completed on other residents, In services on transfers, bed mobility and Hoyer lifts. In- services on abuse and neglect. Interviews with staff. CNA A and LVN B suspended pending Investigations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675790	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garland Nursing and Rehabilitation	321 N Shiloh Rd Garland, TX 75042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Investigation Summary: On 8/2/24 in the PM. C.N.A. was providing incontinent care for Resident #1, Resident #1 rolled to the mat on the floor. C.N.A. notified LVN B. Nurse and C.N.A. assisted resident back to bed. No Documentation or Notification was given on 8/6/24 Nurse noted left leg swelling, Physician ordered a venous doppler. Doppler study had negative result. On 8/8/24 DR notified of doppler result and ordered x ray. X-rays confirmed proximal tibia and fibula shaft fracture. Administrator notified HHSC of injury of unknown origin Resident was transported to Hospital. In-services were started on Abuse, Neglect and Reporting, Transfer, Bed Mobility and Hoyer lifts. Event policy and notification. During interviews it was determined by CNA A, Resident #1 was picked up off the floor on 8/2/24. She stated that Nurse assisted her putting Resident #1 back to bed. LVN B confirmed that she assisted Resident #1 back to bed. LVN B and CNA A were suspended pending investigation. HHSC Investigator entered the building on 8/9/24 at 3:15 pm, HHSC reentered on 8/11/24 IJ was put in place at 5:30 pm. HHSC lowered the IJ 8/12/24 at 7:30 pm. Staff members LVN B and CNA A were terminated. Where others notified: Physician, RP, Ombudsman, Police, HHSC Facility investigation findings: Confirmed Provider action taken post investigation: HHSC onsite 8/09/24, 8/11/24, 8/12/24, Resident returned to facility 8/12/24, In-services on abuse neglect, reporting, Bed mobility and transfer, Events documentation and reporting to appropriate people with evidence based follow up. LVN B and CNA A were suspended and terminated. Record review of : Employee Statements dated 8/8/24, 8/9/24, Safe Survey Resident Interviews dated 8/9/24, Inservice trainings: Abuse and neglect definitions in-service dated 8/8/24, Check offs: Moving/positioning, assisting with dated 8/11/24, 8/12/24, Post Fall Physical Assessment Test dated 8/11/24, 8/12/24, Transfer training and bed mobility dated 8/9/24, Notification of change training dated 8/9/24, Employee Abuse investigation questionnaire dated 8/9/24, LVN B Employee Corrective Action Form suspended dated 8/9/24 and CNA A Employee Corrective Action Form suspended dated 8/9/24. [END] Record review of LVN B's Timesheet printed on 08/09/24 revealed she worked on: 08/02/24 5:45 pm - 7:40 am, 08/06/24 5:30 pm - 7:46 am, 08/07/24 5:26 pm - 7:51 am. Record review of an Article Tibia & Fibula Fracture (Broken Shinbone/Calf Bone) (clevelandclinic.org) last reviewed 06/01/23 revealed, Overview: What are tibia and fibula fractures? Tibia and fibula fractures are two broken bones in your lower leg. Your tibia is your shin bone. Your fibula is your calf bone. Because they're usually caused by major trauma like car accidents or falls, people often break both their tibia and fibula during the same injury. It's rare, but you can fracture one of your tibia or fibula without breaking the other. You might need surgery to repair your bones and physical therapy to regain your ability to move your leg. Record review of the facility's Incident/Accident policy revised July 2017 revealed, Policy statement: All accidents or incidents involving residents .ocurring on our premises shall be investigateed and reported to the Administrator. Policy: 1. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promply initiate and document investigation of teh accident or incident. The following data , as applicable, shall be included on the Report of Incident/Accident form: a The date and time the incident took place .5. The Nurse Supervisor/Charge Nurse and/or department director or supervisor shall complete a Report of Incident/Accident form and s [TRUNCATED]