| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 675801 | A. Building<br>B. Wing | 08/01/2024 |

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| Gilmer Nursing and Rehabilitation | 703 Titus Street<br>Gilmer, TX 75644 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35295<br><br>Based on interviews and record review the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 8 (Resident #1) residents reviewed for quality of care.<br><br>The facility did not ensure Resident #1 was assessed by a nurse after a fall. Resident #1 was improperly transferred to her bed by CNA G and CNA H without first being assessed by the nurse, LVN E.<br><br>The noncompliance was identified as PNC. The IJ began on 1/30/24 and ended on 2/2/24. The facility had corrected the noncompliance before the investigation began.<br><br>These failures could place residents at risk of serious harm, and not receiving the necessary interventions to reach their highest practicable physical, mental, and psychosocial well-being.<br><br>Findings included:<br><br>Record review of the undated face sheet revealed Resident #1 was an [AGE] year-old female that admitted [DATE].<br><br>Record review of the physician's orders dated 7/30/24 revealed Resident #1 had diagnoses that included: Alzheimer's Disease (a type of dementia that was progressive leading to loss of ability to carry on a conversation), chronic pain (long lasting or constantly recurring pain), Type 2 Diabetes (the body cannot control sugar), Osteoarthritis (flexible tissue at the ends of bones wears down), and Generalized Anxiety Disorder (severe, ongoing anxiety that interferes with daily activities), and hypertension (force of blood against the artery walls is too high). The physician's orders revealed she was on hospice services due to Alzheimer's disease at admit (9/11/23).<br><br>Record review of the quarterly MDS revealed Resident #1 had no speech, rarely understood others and was sometimes understood by others. She had a BIMS score of 5 indicating severe cognitive impairment. Resident #1 required substantial/maximum assistance (staff did more than half the work) for her to go from a sitting to standing position and for her to walk 10 feet. She used a manual wheelchair.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of the care plan dated 10/6/23 revealed Resident #1 had impaired cognitive function/dementia or impaired thought processes. She was at risk for falls with interventions including: Anticipate and meet the resident's needs, provide a safe environment, and needs activities that minimize the potential for falls with diversion and distraction. Resident #1 was receiving hospice services due to a terminal illness. A care plan revision on 2/2/24 indicated she had a right hip fracture (break) and was totally dependent on staff for turning and repositioning in bed.<br><br>Record review of an incident report dated 1/30/24 at 5:07 AM revealed Resident #1 was sitting on the couch in the common area and got up to walk, and fell on to her buttocks. Resident #1 was unable to give a description of what had happened. She was assessed with no bruises, scratches or skin tears, range of motion unchanged, voided and no complaints of pain or tenderness. Resident #1 was not taken to the hospital. The incident report indicated there were no injuries observed at the time of incident.<br><br>Record review of the PIR dated 1/30/24 revealed:<br><br>LVN A reported at 9:23 AM, Resident #1 was complaining of pain to her right hip/thigh area and was unable to bear weight on it. Right leg appeared to rotate outward. Resident #1 administered pain medication per PRN order. Call placed to hospice and MD with new order for x-ray of right hip/thigh with 2 views.<br><br>Portable x-ray came out to perform an x-ray and the report was back at 7:16 PM indicating, There is an acute fracture of the proximal femur noted. There is not soft tissue swelling or foreign body identified.<br><br>Record review of an undated, unsigned portion of the PIR indicated:<br><br>Record review of a Neurological Assessment indicated Resident #1 had neurological assessments beginning 1/30/24 through 2/1/24 with no abnormal indications.<br><br>Resident #1 was complaining of pain and refusing to bear weight on the morning of 1/20/24. LVN A performed an assessment and noticed possible external rotation to her right leg. LVN A notified the DON of her assessment and that the resident had a fall on the previous shift. LVN A notified the MD who gave an order for an x-ray and she administered pain medication. Resident #1 was kept in bed and monitored for the effectiveness of pain medication. The family was notified of Resident #1's status and the order for mobile x-ray, to which she agreed, rather than sending Resident #1 out to the ER due to her Alzheimer's diagnosis. X-ray results were received by LVN A around 6:00 PM on 1/30/24 confirming right femur fracture.<br><br>ADM was notified of the X-ray results on 1/30/24 around 7:30 PM. Documentation was reviewed to determine how the fracture possibly occurred. Resident #1 had a fall on 1/30/24 during the early morning hours. The incident report was marked as witnessed; however, witness statements were unable to be located. LVN E, who was the charge nurse on duty at the time of the incident was interviewed to determine how the fall occurred and who witnessed the fall.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | LVN E stated that on 1/30/24 around 5:00 AM she was told by CNA's G and H that Resident #1 was sitting on the couch, stood up, then fell down. When she went to assess Resident #1, she was lying in bed toward her right side, she had her eyes closed with no signs or symptoms of pain or distress. LVN E pulled Resident #1's covers back and assessed her lying on her back, she noted no bruising or skin tears. She asked Resident #1 if she was hurting and her answer was no.<br><br>On 1/31/24 CNA G stated that she saw Resident #1 going back into her room. She looked away for a second and when she looked back, Resident #1 kind of tripped on her foot and she went down slowly. As far as hearing anything Resident #1 didn't really make a sound. They transferred Resident #1 to her bed with CNA G holding her feet and CNA H holding her arms underneath. When they informed LVN E of the fall and what they did, it was round 4:40 AM or 4:50 AM.<br><br>On 1/31/24 CNA G stated that Resident #1 was walking by herself towards her room, and she just collapsed to the ground. She was looking down at first and about 5 minutes later she looked up and heard like a thump and saw Resident #1 was on the floor. They transferred Resident #1 to bed with CNA H holding her top part and CNA G holding her feet. They got her off the floor because they didn't want to leave her there. CNA G and CNA explained to LVN E, that they didn't see her at first, so they proceeded to put her to bed together to get her off the floor.<br><br>More than likely the fracture occurred from her falling to her right side. We were unable to determine when the fracture actually occurred. Therefore, the injury of unknown origin has been marked as inconclusive.<br><br>Resident #1's pain will be managed. On 1/30/24 oxycodone 5 mg, 1 tab po every 4 hours PRN was added, and her codeine-acetaminophen 30 mg/300 mg 1 tab po was increased from every 6 hours to every 4 hours PRN. On 2/1/24 a new order was given for oxycodone 5 mg 1 tab every 8 hours routine. On 2/2/24 a wedge (cushion to aide in positioning for comfort) was obtained to help with the healing process and comfort. Resident #1 was placed on a low air loss mattress on 2/2/24 and received a foley catheter for comfort to help decrease the amount of time when will have to be moved for care.<br><br>Record review of an Incident Statement from CNA H dated 1/31/24 indicated:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #1 was wearing a purple shirt, black shoes, and unsure on the pants. It was a clear area, nothing was round her (Resident #1). She was walking by herself towards her room and she just collapsed to the ground. I was looking down and at first and about 5 minutes later I looked up and heard a thump and seen Resident #1 was on the floor. Previously, before the incident she was up the majority of the night which was not normal for her. She would keep walking around and her leg was swollen. I reported to the nurse around 8-9:00 PM about Resident #1's leg being swollen when she walked into the unit. It was between 9-9:30 PM when Resident #1 was constantly keep getting up on her own, restless. Falling asleep and kept moving around and me and the other aide kept putting her in bed to give her feet some rest. CNA G seen the actual fall and I had just looked up when I heard a thump and seen Resident #1 on the ground. First when I seen her she was on the floor and me and CNA G around 2:30 AM or 3:00 AM went to the nurse station and I noticed Resident #1 wasn't there. So, me and CNA G got on both ends with CNA G holding her feet and me holding her top part we transferred Resident #1 onto the bed. We got her off the floor because we didn't want to leave her there. Resident #1 wasn't getting fussy until we had to get her in bed. We continued to do our checking through the unit and [illegible] waited on the nurse to come back. We started our actual round at 4:00 AM- 4:20 AM and did our normal routine going through residents. CNA G went in room on last round to check on Resident #1 and change her and that's when CNA G came out and notified me that Resident #1 was fussing about her side hurt. I was already getting ready to go out to B-wing to finish up my round and that's when I seen the nurse and notified what was going on. Nurse spoke and said thank you for letting me know and said she was going to go check in. Me and CNA G even explained to her and said we didn't see you at first and so me and CNA G proceeded to let her know we put her in bed together to get her off the floor. Nurse replied with thank you again. When talking to the nurse, when I seen her, it was about 4:40 AM.<br><br>Record review of an Incident Statement dated 1/31/24 from CNA G indicated:<br><br>Resident #1 was wearing black shoes, shirt, and pants. The area was well lit and the only thing that was round was the cart. There was no spills on the floor nor was there clutter. I saw Resident #1 going back into her room, I looked away for a second and I looked back. She kind of tripped on her foot and she went down slowly. She did not really make a sound. When we (CNA G and CNA H) transferred Resident #1 I had her feet and the other CNA had her arms underneath and we both picked her up and laid her in the bed. When informed the nurse that was working that night I let her know that while I was changing Resident #1 she was screaming in pain and she was fighting me which is not normal for her. I also informed the nurse that I did check for bruises or scars, red areas and I told the nurse I didn't see any. The nurse reply was 'Okay, that's fine and thank you for checking for bruises.' From the best of my knowledge the falfl happened around 2:00 AM and when we went to report the fall to the nurse she wasn't there but when I informed the nurse on my side of the story and I told her what I did it was around 4:40 AM or 4:50 AM .<br><br>Record review of an Incident Statement dated 1/30/24 from LVN E indicated:<br><br>4:51 AM, CNA opened nurse station door and reported Resident #1 had fallen, that is all she said then left to go to B-wing to do a round. I went to assess Resident #1. Resident #1 was wearing black and white pajamas and tennis shoes. When I responded Resident #1 was in her bed. She was quiet and resting comfortably. I entered room, Resident #1 was resting, eyes closed, no signs or symptoms of pain or distress. I assessed her lying on her back. I noted no bruising or skin tears. I asked Resident #1 if she was hurting and she answered no.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Record review of an Employee Disciplinary Report dated 1/30/24 indicated LVN E will be placed on an investigatory suspension pending an investigation into allegations of failure to report. The report indicated she would be suspended pending the investigation. CNA reported resident had fallen-nothing about pain, did not say they moved her to bed.<br><br>Record review of an Employee Disciplinary Report dated 1/30/24 indicated LVN E will be placed on an investigatory suspension pending an investigation into allegations of delay to assess in a proper manner.<br><br>Record review of an Employee Disciplinary Report indicated CNA G was suspended 1/30/24, terminated 2/7/24, and her last day to work was 1/30/24.<br><br>Record review of an Employee Disciplinary Report indicated CNA H was suspended 1/30/24, terminated 2/7/24, and her last day to work was 1/30/24.<br><br>Record review of an undated statement from the DON indicated:<br><br>I [name], DON reviewed surveillance with the ADM after an event. A resident in the unit had a fall and it was reported that it was witnessed in the common area. I witnessed the aides transferring our resident inappropriately prior to being assessed by the nurse. The nurse was not notified until approximately 1 hour later.<br><br>Record review of a statement from the ADM dated 2/6/24 indicated:<br><br>I [name], ADM, reviewed surveillance with the DON after a fracture that allegedly occurred from a fall. The fall was around 3:53 AM. I witnessed CNA G and CNA H immediately take Resident #1 under her arms and drag her to her room. They notified the nurse at 4:51 AM.<br><br>Record review of a Patient Report dated 1/30/24 indicated Resident #1 had a right radiologic examination, femur and the findings revealed: Acute fracture of the proximal femur notes .Acute commminuted fracture of the proximal femur is seen.<br><br>During an interview on 7/29/24 at 4:16 PM, Family Member Y said Resident #1 had been on hospice since August of 2023. She said when Resident #1 fell on [DATE], 2 CNA's picked her up inappropriately, one by her feet and one under her arms before she was assessed by a nurse. She said the nurse, was checking in medications and did not know Resident #1 fell . She said the nurse did not know she fell until later. She said the CNA's did not follow protocol. She said Resident #1 was on a lot of narcotics but her pain was controlled. She said the staff fed her. She said Resident #1 was bed bound after the fall because she was not a candidate for surgery. She said Resident #1 passed away 5/20/24.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 7/30/24 at 12:30 PM, LVN D said she took care of Resident #1 sometimes after she came out of the secure unit. She said Resident #1 had fallen and broken her hip but she did not remember the date. She said she was bed bound after that. She said she was able feed herself until the very end and they provided cueing. She said she did not think the hip fracture led to her death, because she had a lot of comorbidities. She said Resident #1's pain was controlled with medication. She said she did not have a lot of pain meds, but she was on hospice and had scheduled pain medications. She said she did not seem groggy, and was easy to wake up if asleep. She said after the hip fracture Resident #1 could not get out of bed anymore. LVN D said when she cared for Resident #1 she was happy, talking, thriving, but she had declined mentally. She said mobility wise Resident #1 seemed happy.<br><br>During an interview on 7/30/24 at 1:06 PM, the ADM said Resident #1 fell in the middle of the hall. She had been having snacks and she was coloring but not really engaging in the activity. The ADM said the CNA's moved her from the floor and should not have moved her. She said the CNA's got her back in bed and then told the nurse she had fallen. The ADM said she saw the video (no longer available-due to being recorded over). The video showed one CNA got her from behind and under the arms and the other CNA stood by. She said the CNA backed/dragged Resident #1 into her room and she did not know how they got her in the bed. She said she did not remember if Resident #1's feet were moving (as if stepping) or if dragging. She said when she saw the video she did not see anyone grab her by her feet but the video was in the hallway, not the bedroom. She said her bed was 10 feet from her fall. She said CNA's G and H were fired and both admitted they did not get the nurse (LVN E) before moving Resident #1. She said the video showed CNA G and CNA H coming out of the room after putting Resident #1 in bed. The ADM said the CNA's went to look for the nurse then when they did not see her they continued to do their rounds. As soon as the CNA's saw the nurse, in less than one hour, then they told her nurse about the fall. Resident #1 was asleep when LVN E went to assess her. When LVN E assessed Resident #1 she did not see anything [NAME]. She said LVN E reported to LVN A (the oncoming day nurse). The ADM said she thought the morning routine started then LVN A thought Resident #1 was in pain or the Resident #1 complained about pain. She said Resident #1 had multiple falls. ADM said she the CNA was behind her and got her to bed by holding her from under the arms and pulling backwards.<br><br>During an interview on 7/30/24 at 1:35 PM, LVN A said she came on shift 1/30/24. She said she went to get Resident #1 up for some reason, maybe breakfast and her leg had an internal rotation. She said Resident #1 was complaining of pain when she tried to use her leg. She said she medicated her for pain and contacted the physician. She said she had an x-ray to the best of her knowledge but could not remember if they sent her out for the x-ray or if it was in-house, but the results showed a hip fracture. She said Resident #1 moved to A-wing shortly after (non-secure unit). She said they did not do surgery as she remembered. She said LVN E told her the aides had already transferred Resident #1 to the bed when she saw her, and the aides had done it wrong. She said she thought she had a femur or hip fracture. LVN A said Resident #1's hip could have broken then she fell , or fell and it caused the break, she said there was no way to know. She said prior to the fall Resident #1 needed help to walk and staff assisted her. She said she also used a wheelchair. She said she was not with it mentally, but could carry on a conversation and the subject changed repeatedly. She stated she could tell you if she was in pain. However, she was not reliable to tell you what had happened.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 7/30/24 at 3:16 PM, LVN F said she was not in the facility when Resident #1 fell and she did not work on the unit. She said after she left the secure unit she cared for her. She said after the fall Resident #1 got scheduled pain medications. She said she did not appear to be out of it and would try to get out of bed. She said she was not sedated. She said her scheduled pain medication put her in a good place. She said Resident #1 would yell sometimes from anxiety and she thought she had medication for that. She said she did not think the fall/fracture contributed to her death, because she was on hospice and lived for several months after the fall. She said CNA's cannot get residents up if they fall or are on the floor. A nurse had to assess the resident before they were moved. She said she believed all the CNA's knew that because they always went to get her to assess if a resident was found in the floor.<br><br>During an attempted phone interview on 7/30/34 at 3:40 PM, called CNA G. She did not answer, and this surveyor left a message requesting a return call.<br><br>During a phone interview on 7/30/34 at 3:51 PM, Resident #1's Hospice nurse said she had followed the natural progression of the Alzheimer's Disease process and did not believe the fall/fracture contributed to her death due to the time frame. After the fall her pain was well managed. She said the family and the Hospice Medical Director decided she was not a surgical candidate, so they kept her as comfortable as possible. She said Resident #1 was not groggy, had lots of visits with family and was able to hold her new grandbaby. She said her decline was natural. She said they gave her scheduled oxycodone and did a wedge (a type of pillow for positioning for comfort) positioner for her fracture. She said hospice made multiple medication changes to meet her needs regarding pain and comfort.<br><br>During an interview on 7/30/24 at 6:23 PM, LVN E said CNA G and CNA H told her Resident #1 had fallen, and the CNA's had already put her back in bed. She said she told them they were not supposed to do that and did not remember their reaction. She said she was not sure how long it was from the time Resident #1 fell until she was told about it and assessed her. She said it was only a few minutes, not hours. She said the CNA's said they knew they were not supposed to transfer her until a nurse had assessed her. She did not know why they had done that. She said both CNA G and CNA H were fired. She said before the CNA's left to do their rounds on B hall they let her know that Resident #1 had fallen, and they had put her back into bed. LVN E said she went to assess Resident #1 as soon as the CNA's told her she had fallen. She said she did not take her clothes off and could not remember what she was wearing but said she could see her legs and nothing looked out of the ordinary. She said she had heavy thighs and had lost weight so she had some lose skin and she could have missed something because of that. She asked Resident #1 if she was in pain and said she denied any pain. She had no skin tears or bruising. She said she raised her top/shirt and did not see any injuries but did not remove the clothing from her bottom half and could not remember what she had on. She said either she turned Resident #1 to check her back or Resident #1 turned for her and she did not yell or appear to be in pain. She did not cry out when she turned. She said she checked leg length and bent both her legs and saw nothing out of the ordinary. She said when checking her legs and bending them Resident #1 did not appear to be in pain and did not complain of pain.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 7/31/24 at 8:14 AM, the DON said she assessed Resident #1 after LVN A. She asked her if she was having any pain and she said no, it only hurt when she moved her leg. She said she did not attempt to move her leg or her. She said she did not see a deformity of her leg. The DON said she did not remember what she was wearing or how she was able to see her legs. LVN A told her she had ordered an x-ray. She said it was hard to remember details, because it was in January. She said she did not do anything because the x-ray had been ordered. She said she did not document this assessment but was sure she made sure LVN A had given her pain medication. She said she did not have a good answer as to why she did not document her assessment.<br><br>During an interview on 7/31/24 at 11:05 AM, LVN J said if a resident fell , she would assess, start neuros if unwitnessed, notify the MD, DON, family, and the ADM as soon as possible. She said she had been in-serviced on falls, X-ray's and numerous things regarding falls. She said a CNA should never transfer a resident after a fall, the nurse had to be notified to assess the resident. She said if a stat X-ray could not be done within 2 hours she would call the NP or the MD to see about sending the resident to the hospital. She said if a resident could not safely get off the floor after the nursing assessment, she would call the MD and EMS. She said if a resident was not in pain and she did not suspect a fracture, she could wait 4 hours on the X-ray.<br><br>During an interview on 7/31/24 at 11:11 AM, RN B if a resident fell she would assess, do vitals, let the ADON, DON, and the nurse know. Notify the MD quickly, within 10-15 minutes. Call EMS if warranted (bleeding). She said she has been at the facility 2 weeks. She had in-services on fall prevention, X-rays, notification of MD, and numerous others. She said if a resident had a possible fracture, and the stat X-ray was not done within an hour she would call the MD to send the resident to the hospital. She said a CNA was never to transfer a resident that had fallen because they had to get the nurse to assess. She would call EMS if a resident could not safely be gotten up.<br><br>During an interview on 7/31/24 at 11:12 AM, LVN T said if a resident fell she would assess the resident, take vital signs, and make sure they could move their limbs. She said a CNA would assist the nurse to move them back to bed. She said she would medicate the resident if needed, notify the doctor, family, the ADM, the ADON, and the DON. LVN T said she would do neurological assessments if the fall was unwitnessed. She said she would do a risk management Kardex and a fall note. If a fracture was suspected she would not move the resident, she would contact the MD and notify of a suspected fracture, call EMS and send the resident to the ER. Send to ER. She said she would notify the resident's family, and offer pain medication to the resident. She said for a STAT x-ray she would notify the doctor if they had not done the x-ray after a couple of hours.<br><br>During an interview on 7/31/24 at 11:18 AM, LVN L said if a resident fell , she would assess the resident, then notify the the ADON, the DON, and the MD. She said she would get the resident off the floor and to their bed if fracture was not suspected. She said if a fracture was suspected she would call EMS and sent the resident to the hospital. She said she would notify all administration staff. LVN L said she would expect a STAT X-ray in 2-4 hours and if the resident did not get their x-ray timely she would notify MD to see if he wanted the resident to be sent to ER.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675801 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gilmer Nursing and Rehabilitation | 703 Titus Street<br>Gilmer, TX 75644 |

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

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 7/31/24 at 11:21 AM, CNA K said if she found a resident in the floor, she would have someone stay with the resident while she found the nurse. She said if there was no one to stay with the resident she would turn the call light on and look out the door for someone to go get the nurse. She said you never ever transfer a resident that had fallen or was in the floor, no matter how long it took the nurse to get there. CNA K said you could hurt the resident worse than they were by transferring them. She said pulling a resident up by their arms or feet was improper and could hurt them and she stated staff had to use a gait belt, unless the resident required a hoyer lift then 2 staff were required. She said she had numerous in-services on resident's falling, notifying the nurse, fall prevention, etc. She said if she saw another CNA attempting to get a resident off the floor before a nurse assessment she would tell them to stop, the nurse had to assess for the safety of the resident.<br><br>During an interview on 7/31/24 at 11:22AM, LVN V said if a resident fell he would do a total assessment in the location where he found the resident, check vital signs, assess for pain and medicate, check for wounds, and initiate neuros if necessary. LVN V said he would notify the DON, the ADM, family, and the MD. If a fracture was suspected, he would call 911. He said he would not wait on the X-ray company to arrive and if it was a STAT X-ray and they were not at the facility within an hour he would call the MD and send the resident to the hospital if necessary.<br><br>During an interview on 7/31/24 at 11:27 AM, LVN L said if a resident fell she would assess the resident, then if no injury she would assist them to get back in bed. She said if there was an injury she would not move the resident and would call 911 for transport to the hospital. LVN L said she would notify the the MD, the DON, the ADM, and family immediately. She said 1-2 hours was too long for notification. She said 30 min-1 hour is reasonable time to give notification because you had to take care of the resident. She had in-services on fall prevention, ANE, x-rays, notification, SBAR, and many other in-services. She said 4 hours was reasonable if the resident had no suspected injury. If a resident was in pain, she felt 1 hour was reasonable. She said if a resident was in pain, and she suspected a fracture she would just send them out. She said if a resident fell or was found in the floor, a CNA had to get the nurse to assess the resident prior to moving the resident to prevent harm.<br><br>During an interview on 7/31/24 at 11:48 AM, CNA W said if a resident fell she was going to get the charge nurse. She said she would stay with the resident and yell for a nurse if necessary. She said she would call someone on her phone, stick her head out the door and yell if she needed to because she could not leave the resident. If a long time passed, then they she would call EMS. Do not move the resident no matter what because you do not want to make an injury or fracture worse. It was important for the nurse to be notified so they could do a thorough assessment and ensure there were no injuries. She said she had many in-services on not moving a resident and getting the nurse as soon as possible.<br><br>During an interview on 7/31/24 at 11:49 AM, CNA M said if a resident fell she would get a nurse. She said she would watch the resident and yell until she got a nurse to come. She said she could stick her head out the door and look for someone, call someone on her cell phone, but she would not leave them. She said if a nurse had not gotten there in 10 minutes she would call EMS. She said she would not move the resident no matter what. She said moving a resident before a nurse saw them could make their injury worse. The nurse had to see the resident to make sure nothing was broken or no internal injuries. She said she had numerous in-services on falls, notifying the nurse, and change in condition. No matter what the injury on the resident, or no injury, she had to get the nurse immediately.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | During an interview on 7/31/24 at 11:54 AM, CNA R said if a resident fell , she would notify the nurse and stay with the resident. She would attempt to find a nurse by yelling for one or using her phone to call the nurse. She would call EMS if necessary. She said the nurse had to be notified so the resident could be assessed and receive further treatment if needed. She would not move the resident. She said she had been in- serviced on residents falling and notifying the nurse.<br><br>During an interview on 7/31/24 at 12:01, CNA N said she had many in-services regarding falls, change of condition, notifying the nurse, and abuse and neglect etc. She said if she found a resident in the floor, she would never move him/her or try to get them up. She said she had to get a nurse to assess the resident before touching the resident. She said she would make sure the resident was safe then stick her head out the door and holler for a nurse, call a nurse on the her phone, or have someone get a nurse. She said if the resident was screaming in pain and the nurse did not get there quickly, she would call 911.<br><br>During an interview on 7/31/24 at 1:02 PM, LVN E said the night CNA's (CNA G and CNA H) never told her that Resident #1 was hurting or in pain after her fall. She said if they had, she would have reassessed her and sent her to the ER.<br><br>During an interview on 7/31/24 at 1:43 PM, the ADON said the transfer with Resident #1 was an improper and dangerous transfer. She said the CNA's should not have done that. She said the risk could have been serious bodily injury. She said Resident #1 got a serious bodily injury that day, but it was unclear how. She said all staff had extensive in-services for an extended period of time and were trained and re-trained. All CNA's know that they should not ever move a resident prior to a nurse assessing them.<br><br>During an interview on 7/31/24 at 1:51 PM, the DON said the CNA G and CNA H transferred Resident #1 improperly. She said that had the potential to result in serious bodily injury. She said Resident #1 had a femur fracture but it could not be determined if it occurred before the fall, after the fall, or the improper transfer. The CNA's were suspended pending investigation and then terminated after the investigation. She said LVN E was also suspended pending investigation. The DON said all staff had been in-serviced extensively regarding x-ray time expectations, reporting, change of condition, what to do in the event of a fall or a resident found in the floor, proper assessment, notifying the MD & family, all notifications, abuse and neglect, SBAR and several others. She said they did in-services for |