STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675806	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment and the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one of 5 residents (Resident #1) reviewed for care plans. 1. The facility failed to ensure the comprehensive care plan for Resident #1 was developed to accurately address the resident's need for dining assistance. 2. The facility failed to ensure Resident #1's bed was in the lowest position possible as noted in the care plan while the resident was lying in bed. Resident #1, noted to be at risk for falls, fell out of bed and sustained a left shoulder injury. This failure could place residents at risk for not receiving care and services to meet their needs. Findings include: 1. Record review of Resident #1's face sheet, dated 4/02/24, reflected an [AGE] year-old female who was readmitted to the facility on [DATE]. Relevant diagnoses included Alzheimer's Disease unspecified (a progressive brain disorder, leads to changes in memory, thinking, and behavior), Major Depressive Disorder, recurrent, unspecified (mood disorder characterized by persistent feelings of sadness and hopelessness, often accompanied by a loss of interest in activities they once enjoyed), Dysphagia, oropharyngeal phase (disorder or impairment in the ability to swallow), Muscle Wasting and Atrophy, not elsewhere classified (loss or thinning of muscle tissue), and Other, Lack of Coordination. Record review of Resident #1's quarterly MDS assessment, dated 3/28/24, reflected she was severely cognitively impaired with a BIMS score of 03. She required Substantial/Maximal assistance with eating. She was fully dependent with toileting/hygiene, shower/bathing self, upper body dressing, and lower body dressing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Comprehensive Care Plan reflected she had an ADL Self Care Performance Deficit related to Alzheimer's Disease. Her goals included she would maintain current level of function through the review date and she would improve current level of function through the review date. Related intervention reflected Resident #1 was independent with eating with setup assistance and monitoring . Resident #1's care plan did not address the resident's need for dining assistance. Record review of Resident #1's Intake records, accessed on 4/04/24, reflected from 3/22/24 to 4/04/24, Resident #1 consumed 41 meals as follows: 22 meals at 51-75% 9 meals at 26-50% 6 meals at 76-100% 4 meals at 0-25% Interview on 4/02/24 at 9:51 AM with Resident #1 was unsuccessful due to the resident's communication and cognitive limitations. Observation on 4/02/24 at 12:33 PM revealed lunch was delivered to Resident #1. Nurse Aide A was observed assisting the resident with eating. In an interview on 4/02/24 at 12:34 PM with Nurse Aide A, she stated Resident #1 did not need assistance with eating. She stated the resident only required encouragement and supervision. She stated the resident's food intake was recorded in her chart. In an interview on 4/02/24 at 12:50 PM with the ADON, she stated Resident #1 could not eat independently. She stated care plans were updated quarterly and with any change in the residents' condition. She stated the DON updated the care plans. Interview with Resident #1's physician on 4/02/24 at 1:10 PM and on 4/04/24 at 12:02 PM were unsuccessful. In an interview on 4/02/24 at 1:45 PM with the Dietary manager, she stated the leadership staff had care plan meetings once a week. She stated Resident #1 was on a low sodium diet. The Dietary manager stated Resident #1 did not feed herself independently. She stated the resident ate in the assisted dining room. The Dietary manager stated nurse leadership was responsible for updating the residents' care plans. In an interview on 4/02/24 at 2:26 PM with the Social Worker, she stated she was responsible for organizing weekly SOC and Care Plan meetings. She stated the facility leaders attended the meetings to discuss resident concerns and the DON updated the residents' care plans accordingly. Interview with Resident #1's representative on 4/02/24 at 2:42 PM was unsuccessful. Voicemail was left with a call back number. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/02/24 at 4:34 PM with the DON, she stated care plans were updated quarterly and as needed based on the residents' needs and the SOC meetings. She stated SOC meetings addressed interventions with nursing, the NP, therapy, the social worker, ADON, treatment nurse and the dietician. She stated the resident recently had a decline in her disease process. She stated Resident #1 could not eat independently and the aides were aware they needed to assist the resident with her meals. The DON stated the interdisciplinary team, which included nurse leadership, was responsible for updating resident care plans . In an interview on 4/02/24 at 5:17 PM with Resident #1's representative, he stated the resident needed assistance with feeding but did not know if the aides were helping her eat. The interview was cut short due to his time constraints. Interview on 4/04/24 at 1:35 PM with Resident #1's representative was reattempted but was unsuccessful. In an interview on 4/04/24 at 10:21 AM with the Dietician, he stated Resident #1 could not eat independently. He stated she needed assistance due to her cognitive and physical limitations. He stated he could just look at Resident #1 and determine she could not feed herself. He stated he believed it was the DON and ADON's responsibility to update care plans. 2. Record review of Resident #1's face sheet, accessed on 4/02/24, reflected an [AGE] year-old female who was readmitted to the facility on [DATE]. Relevant diagnoses included Alzheimer's Disease, unspecified (a progressive brain disorder, leads to changes in memory, thinking, and behavior), Acquired absence of Left leg above the knee (above the knee amputation), Muscle Wasting and Atrophy, not elsewhere classified (loss or thinning of muscle tissue), and Other, Lack of Coordination. Record review of Resident #1's quarterly MDS assessment, dated 3/28/24, reflected she was severely cognitively impaired with a BIMS score of 03. She was fully dependent on two staff for bed mobility, repositioning, and transfers. Record review of Resident #1's Comprehensive Care Plan, accessed on 4/02/24, reflected she was at risk for falls related to Alzheimer's Disease. Related goals, initiated on 1/24/24 with a target goal date of 4/23/24, reflected the following: I will not sustain serious injury through the review date . I will be free of minor injury through the review date . I will be free of falls through the review date Related interventions included, bed in the lowest position possible. The Care Plan further reflected Resident #1 sustained a fall on 3/26/24. Record review of Resident #1's Nurse's Notes reflected the resident sustained a fall on 3/29/24: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/29/24 at 9:10 PM authored by the Wound Nurse revealed, Writer notified of resident laying on floor. Upon entering room, resident awake, alert as per resident normal, laying towards left side on floor next to bed, head resting hands on base of bedside table. No immediate signs of pain or distress. Denies pain when asked. Able to move all extremities as per normal. Redness noted to left side of face and shoulder. Assisted onto bed X 4 staff. Record review of Resident #1's Radiologic Report, dated 3/30/24 at 5:04 AM by the Radiologist, included the following: Left shoulder x-ray complete, two or more views. Impression reflected: Inferior and medial dislocation in relation to the glenoid (the socket of the ball-and-socket shoulder joint). Left Humerus x-ray, two views. Impression reflected: Inferior and medial dislocation in relation to the glenoid. Record review of Resident #1's hospital After Visit Summary, dated 4/01/24 at 5:41 PM, reflected the resident was admitted to the emergency department on 4/01/24 with a complaint of shoulder pain. Imaging was conducted of Resident #1's Right foot and Left shoulder . Observation on 4/02/24 at 9:52 AM revealed Resident #1 was resting in bed. The bed was in a high position, no fall mats were present, and a wedge pillow was sitting on the resident's night stand next to the resident's bed. Observation on 4/02/24 at 11:29 AM revealed Resident #1's resting in bed with bed in a high position. Interview on 4/02/24 at 9:51 AM with Resident #1 was unsuccessful due to the resident's communication and cognitive limitations. In an interview on 4/02/24 at 12:44 PM with Nurse Aide A, she stated Resident #1's bed was not in the lowest position. She stated the resident was not a fall risk. In an interview on 4/02/24 at 12:50 PM with the ADON, she stated the bed was not in the lowest position possible. She stated the resident was a fall risk, and the bed should be in a low position. She stated injury was a possibility if the bed was in a high position. Interview with Resident #1's physician on 4/02/24 at 1:10 PM and on 4/04/24 at 12:02 PM were unsuccessful. In an interview on 4/02/24 at 1:50 PM with LVN B, he stated Resident #1 had never fallen before except in the last week. He stated he was not working when the resident fell . LVN B stated Resident #1 was a fall risk, and her bed should be in the lowest possible position. He stated if it was not in the lowest position, the resident could fall out of bed. He stated he checked bed heights during his rounds when he went to work. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/02/24 at 2:02 PM with the Physical Therapy Director, she stated Resident #1 was not receiving physical or occupational therapy. She stated the resident was discharged because she had plateaued. She stated Resident #1's last PT treatment was on 2/23/24 and her last OT treatment was on 3/01/24. She stated Resident #1 was a fall risk. She stated the resident could not transfer or reposition herself in bed; she needed complete assistance. She stated the aides must reposition her in bed and in her wheelchair. The PT Director stated she thought the aides used wedges to address the resident's fall status. She stated side bed rails were ruled out because Resident #1 did not have the ability to reposition herself. In an interview on 4/02/24 at 2:26 PM with the Social Worker, she stated Resident #1 had recently become a fall risk. She stated as a team, they tried to find interventions to address falls. She stated that primarily, nursing and therapy worked on interventions for resident falls and she was not aware of the interventions for Resident #1. Interview with Resident #1's representative on 4/02/24 at 2:42 PM was unsuccessful. Voicemail was left with a call back number. In an interview on 4/02/24 at 4:34 PM with the DON, she stated Resident #1 had an unwitnessed fall on 3/29/24, had x-rays on her Left shoulder on 3/20/24, and was sent to the emergency roiagnom on [DATE] for a possible dislocation of Resident #1's Left shoulder. She stated the hospital did not verify a dislocation to the resident's shoulder. The DON stated Resident #1 had fallen maybe twice in the past 30 days. She stated that on 3/26/24, the resident fell out of her wheelchair and on 3/29/24, the resident fell from her bed. She stated the resident was completely dependent for transfers and could not independently reposition herself in bed. The DON stated Resident #1 was not a fall risk so bed height was not something that would need to be addressed. She stated for residents who were fall risks, ensuring their beds were in a low position would be the responsibility of nurses, aides, or anyone who saw the bed in a high position. She stated the risks of a high positioned bed for fall risk residents depended on the resident and what their needs were. In an interview on 4/02/24 at 4:50 PM with the Administrator, he stated he was aware of the happenings with the residents but was not really involved in the clinical part. He stated he left that to the DON and ADON and expected them to follow policy and procedures. In an interview on 4/02/24 at 5:17 PM with Resident #1's representative, he stated he received a call from the facility on Sunday night, 3/31/24 to inform him the resident had an unwitnessed fall from her bed. He stated he found it hard to believe she would fall because she could not move by herself. The resident's representative stated he was aware of her emergency room visit but had not heard back from the facility regarding the resident's current condition. The interview was cut short due to his time constraints. Interview on 4/04/24 at 1:35 PM with Resident #1's representative was reattempted but was unsuccessful. Record review of the facility's Comprehensive Care Plans policy, dated December 2023, reflected the following policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive, person-centered care plan will: Include measurable objectives and timeframes. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Incorporate identified problem areas. Reflect treatment goals, timetables, and objectives in measurable outcomes. Aid in preventing or reducing decline in the resident's functional status and/or functional levels. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. Reflect currently recognized standards of practice for problem areas and conditions

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49733 Based on observation, interview and record review the facility failed to ensure each resident's environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one of five residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure Resident #1's bed was in the lowest position possible while the resident was lying in bed. Resident #1 was noted to be at risk for falls. This deficient practice could place residents at risk for falls and could contribute to avoidable falls, resulting in injury. Findings include: Record review of Resident #1's face sheet, accessed on 4/02/24, reflected an [AGE] year-old female who was readmitted to the facility on [DATE]. Relevant diagnoses included Alzheimer's Disease, unspecified (a progressive brain disorder, leads to changes in memory, thinking, and behavior), Acquired absence of Left leg above the knee (above the knee amputation), Muscle Wasting and Atrophy, not elsewhere classified (loss or thinning of muscle tissue), and Other, Lack of Coordination. Record review of Resident #1's quarterly MDS assessment, dated 3/28/24, reflected she was severely cognitively impaired with a BIMS score of 03. She was fully dependent on two staff for bed mobility, repositioning, and transfers. Record review of Resident #1's Comprehensive Care Plan, accessed on 4/02/24, reflected she was at risk for falls related to Alzheimer's Disease. Related goals, initiated on 1/24/24 with a target goal date of 4/23/24, reflected the following: I will not sustain serious injury through the review date . I will be free of minor injury through the review date . I will be free of falls through the review date Related interventions included, bed in the lowest position possible. The Care Plan further reflected Resident #1 sustained a fall on 3/26/24. Record review of Resident #1's Nurse's Notes reflected the resident sustained a fall on 3/29/24: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/29/24 at 9:10 PM authored by the Wound Nurse revealed, Writer notified of resident laying on floor. Upon entering room, resident awake, alert as per resident normal, laying towards left side on floor next to bed, head resting hands on base of bedside table. No immediate signs of pain or distress. Denies pain when asked. Able to move all extremities as per normal. Redness noted to left side of face and shoulder. Assisted onto bed X 4 staff staff .Spoke to [Name], NP and received orders for Neuro checks, hold anticoagulants x 3 days, X-ray; skull series, left arm and left shoulder, and give Norco as prescribed and PRN . Record review of Resident #1's nurse's note, dated 03/30/2024 at 12:30 AM, written by RN C revealed no delayed injuries noted from fall, x-ray skull series, left shoulder and left arm done, awaiting results. Record review of Resident #1's Radiologic Report, dated 3/30/24 at 5:04 AM by the Radiologist, included the following: Left shoulder x-ray complete, two or more views. Impression reflected: Inferior and medial dislocation in relation to the glenoid (the socket of the ball-and-socket shoulder joint). Left Humerus x-ray, two views. Impression reflected: Inferior and medial dislocation in relation to the glenoid. Record review of Resident #1's nurse's note, dated 03/30/2024 at 11:10 PM, written by LVN D revealed Remains on fall follow up with neuro check, no delayed injury noted. Record review of Resident #1's progress note, dated 03/31/2024 revealed Patient seen via telemedicine with nurse - [Name] .transfer to ED for management of left shoulder dislocation. Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:00 PM, written by Wound Nurse revealed X-rays sent to [Provider Name], NP. New order to send to nearest ER for further evaluation. Charge nurse notified. DON notified. Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:22 PM, written by LVN E revealed Nurse informed by Treatment nurse [Name] patient needed to be transferred to [Hospital Name] for possible shoulder dislocation. Nurse was unable to secure non-emergency transport. Nurse called for 911 assistance EMS arrived stating they could not assist with transport d/t situation being non-emergent at this time. Pt x-ray results received on 3/30/24. Nurse informed on call nurse to contact Administrator or DON to escalate the situation d/t all resorts have been done by nurse. Nurse notified family by text and call without a response. Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:24 PM, written by Wound Nurse revealed Received call from charge nurse with 911 paramedics that verbalizing this is a non-emergency and they will not take the resident. Call placed to [Transport Name] in attempt to set up ER transport. Spoke to [Name]. Pick up scheduled for 04/01/2024 at 08:00am. Record review of Resident #1's nurse's note, dated 04/01/2024 at 8:10 AM, written by LVN F revealed Called [Name] transport to see when resident is supposed to be picked up and if stretcher or W/C. Was informed that they were going to pick her up at 0930 AM and by stretch. Stated Ok and thank you. Will continue to monitor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse's note, dated 04/01/2024 at 9:45 AM, written by LVN F revealed [Name] transportation here to take resident to [Hospital Name] ER D/T X-Ray showed a dislocated collarbone/shoulder for further eval. Resident was assisted to stretcher times 3 people 2 EMTS and this nurse. PRN pain med given at this time. Resident left facility via stretcher in stable condition accompanied by 2 EMTS. Record review of Resident #1's hospital After Visit Summary, dated 4/01/24 at 5:41 PM, reflected the resident was admitted to the emergency department on 4/01/24 with a complaint of shoulder pain. Imaging was conducted of Resident #1's Right foot and Left shoulder. Review of hospital records dated 04/01/2024 revealed Resident #1 is a 81 y.o. female with Alzheimer, hyperlipidemia and hypertension presents with left shoulder pain and possible dislocation. Per transfer facility they stated they got films that revealed that patient had a shoulder dislocation brought her into the ER evaluation . Further review revealed X-ray shoulder 2+ view left .Findings: No fracture or dislocation of the left shoulder is seen. Alignment and joint spaces are preserved. Mild glenohumeral and acromioclavicular joint degenerative changes with marginal osteophyte formation. Bones appear demineralized. No erosions or bone destruction. Surrounding soft tissues are unremarkable. Observation on 4/02/24 at 9:52 AM revealed Resident #1 was resting in bed. The bed was in a high position (at waist level), no fall mats were present, and a wedge pillow was sitting on the resident's night stand next to the resident's bed. Observation on 4/02/24 at 11:29 AM revealed Resident #1's resting in bed with bed in a high position (at waist level). Interview on 4/02/24 at 9:51 AM with Resident #1 was unsuccessful due to the resident's communication and cognitive limitations. In an interview on 4/02/24 at 12:44 PM with Nurse Aide A, she stated Resident #1's bed was not in the lowest position. She stated the resident was not a fall risk. In an interview on 4/02/24 at 12:50 PM with the ADON, she stated the bed was not in the lowest position possible. She stated the resident was a fall risk, and the bed should be in a low position. She stated injury was a possibility if the bed was in a high position. Interview with Resident #1's physician on 4/02/24 at 1:10 PM and on 4/04/24 at 12:02 PM were unsuccessful. In an interview on 4/02/24 at 1:50 PM with LVN B, he stated Resident #1 had never fallen before except in the last week . He stated he was not working when the resident fell . LVN B stated Resident #1 was a fall risk, and her bed should be in the lowest possible position. He stated if it was not in the lowest position, the resident could fall out of bed. He stated he checked bed heights during his rounds when he went to work. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/02/24 at 2:02 PM with the Physical Therapy Director, she stated Resident #1 was not receiving physical or occupational therapy. She stated the resident was discharged because she had plateaued. She stated Resident #1's last PT treatment was on 2/23/24 and her last OT treatment was on 3/01/24. She stated Resident #1 was a fall risk. She stated the resident could not transfer or reposition herself in bed; she needed complete assistance. She stated the aides must reposition her in bed and in her wheelchair. The PT Director stated she thought the aides used wedges to address the resident's fall status. She stated side bed rails were ruled out because Resident #1 did not have the ability to reposition herself. In an interview on 4/02/24 at 2:26 PM with the Social Worker, she stated Resident #1 had recently become a fall risk. She stated as a team, they tried to find interventions to address falls. She stated that primarily, nursing and therapy worked on interventions for resident falls and was not aware of the interventions for Resident #1. Interview with Resident #1's representative on 4/02/24 at 2:42 PM was unsuccessful. Voicemail was left with a call back number. In an interview on 4/02/24 at 4:34 PM with the DON, she stated Resident #1 had an unwitnessed fall on 3/29/24, had x-rays on her Left shoulder on 3/20/24, and was sent to the emergency roiagnom on [DATE] for a possible dislocation of Resident #1's Left shoulder. She stated the hospital did not verify a dislocation to the resident's shoulder. The DON stated Resident #1 had fallen maybe twice in the past 30 days. She stated that on 3/26/24, the resident fell out of her wheelchair and on 3/29/24, the resident fell from her bed. She stated the resident was completely dependent for transfers and could not independently reposition herself in bed. The DON stated Resident #1 was not a fall risk so bed height was not something that would need to be addressed. She stated for residents who were fall risks, ensuring their beds were in a low position would be the responsibility of nurses, aides, or anyone who saw the bed in a high position. She stated the risks of a high positioned bed for fall risk residents depended on the resident and what their needs were. In an interview on 4/02/24 at 4:50 PM with the Administrator, he stated he was aware of the happenings with the residents but was not really involved in the clinical part. He stated he left that to the DON and ADON and expected them to follow policy and procedures. In an interview on 4/02/24 at 5:17 PM with Resident #1's representative, he stated he received a call from the facility on Sunday night, 3/31/24 to inform him the resident had an unwitnessed fall from her bed. He stated he found it hard to believe she would fall because she could not move by herself. The resident's representative stated he was aware of her emergency room visit but had not heard back from the facility regarding the resident's current condition. The interview was cut short due to his time constraints. Interview on 4/04/24 at 1:35 PM with Resident #1's representative was reattempted but was unsuccessful. Record review of the facility's Fall In-Service Training Record, dated 3/25/24, administered by Nursing Leadership which consisted of the DON, ADON, and the Wound Nurse to all staff reflected the topic of the training was Fall Prevention Awareness and included the following: Keep bed at lowest position (continued on next page)

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	675806	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurenwood Nursing and Rehabilitation	330 W Camp Wisdom Rd Duncanville, TX 75116

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep floor clutter free Keep call light and familiar items within reach Ensure residents are positioned in bed properly Record review of the facility's Fall - Clinical Protocol, dated December 2023, included the following protocols: As part of the initial assessment, the physician will help identify individuals with a history of fall and risk factors for subsequent falling . In addition, the nurse shall assess and document/report the following: .precipitating factors, details on how fall occurred . The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk . For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall . Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent fall and to address risks of serious consequences of falling . If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interview and record review, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for one (Resident #1) of five residents reviewed for radiology services. The facility failed to retrieve x-ray results for Resident #1's shoulder in a timely manner. This failure could place residents at risk of injury, pain and a delay in treatment. Findings included: Record review of Resident #1's admission record, dated 04/02/2024, revealed an [AGE] year-old female who admitted on [DATE] and readmitted on [DATE] with a diagnosis that included Alzheimer's Disease and acquired absence of left leg above knee. Record review of Resident #'1's Quarterly MDS assessment, dated 03/28/2024, reflected a BIMS of 3 indicating severe cognitive impairment. Record review of Resident #1's care plan, undated, reflected Resident #1 was at risk for falls related to Alzheimer's Disease. Further review of the care plan revealed Resident #1 had an ADL self-care performance deficit r/t Alzheimer's Disease requiring extensive staff assist with transferring, reposition and turning in bed, personal hygiene, extensive assist of 1 staff for toilet use, and 1 staff for dressing and bathing. Record review of Resident #1's nurse's note, dated 03/29/2024 at 9:10 PM, written by Wound Nurse revealed Writer notified of resident laying on floor. Upon entering room, resident awake, alert as per resident normal, laying towards left side on floor next to bed, head resting hands on base of bedside table. No immediate signs of pain or distress. Denies pain when asked. Able to move all extremities as per normal. Redness noted to left side of face and shoulder . Assisted onto bed X 4 staff .Spoke to [Name], NP and received orders for Neuro checks, hold anticoagulants x 3 days, X-ray; skull series, left arm and left shoulder, and give Norco as prescribed and PRN . Record review of Resident #1's nurse's note, dated 03/30/2024 at 12:30 AM, written by RN C revealed no delayed injuries noted from fall, x-ray skull series, left shoulder and left arm done, awaiting results. Record review of Resident #1's nurse's note, dated 03/30/2024 at 11:10 PM, written by LVN D revealed Remains on fall follow up with neuro check, no delayed injury noted. Record review of Resident #1's progress note, dated 03/31/2024 revealed Patient seen via telemedicine with nurse - [Name] .transfer to ED for management of left shoulder dislocation. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:00 PM, written by Wound Nurse revealed X-rays sent to [Provider Name], NP. New order to send to nearest ER for further evaluation. Charge nurse notified. DON notified. Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:22 PM, written by LVN E revealed Nurse informed by Treatment nurse [Name] patient needed to be transferred to [Hospital Name] for possible shoulder dislocation. Nurse was unable to secure non-emergency transport. Nurse called for 911 assistance EMS arrived stating they could not assist with transport d/t situation being non-emergent at this time. Pt x-ray results received on 3/30/24. Nurse informed on call nurse to contact Administrator or DON to escalate the situation d/t all resorts have been done by nurse. Nurse notified family by text and call without a response. Record review of Resident #1's nurse's note, dated 03/31/2024 at 9:24 PM, written by Wound Nurse revealed Received call from charge nurse with 911 paramedics that verbalizing this is a non-emergency and they will not take the resident. Call placed to [Transport Name] in attempt to set up ER transport. Spoke to [Name]. Pick up scheduled for 04/01/2024 at 08:00am. Record review of Resident #1's nurse's note, dated 04/01/2024 at 8:10 AM, written by LVN F revealed Called [Name] transport to see when resident is supposed to be picked up and if stretcher or W/C. Was informed that they was going to pick her up at 0930 AM and by stretch. Stated Ok and thank you. Will continue to monitor. Record review of Resident #1's nurse's note, dated 04/01/2024 at 9:45 AM, written by LVN F revealed [Name] transportation here to take resident to [Hospital Name] ER D/T X-Ray showed a dislocated collarbone/shoulder for further eval. Resident was assisted to stretcher times 3 people 2 EMTS and this nurse. PRN pain med given at this time. Resident left facility via stretcher in stable condition accompanied by 2 EMTS. Record review of Resident #1's Radiology Results Report, dated 03/30/2023 at 5:06 AM reviewed by Wound Nurse on 03/31/2024 at 9:03 PM revealed Left shoulder x-ray complete 2 or more views: .impression: 1. Inferior and medial dislocation of the humerus in relation to the glenoid .Left humerus x-ray - 2 view: . impression: 1. Inferior and medial dislocation of the humerus in relation to the glenoid. Review of hospital records dated 04/01/2024 revealed Resident #1 is a 81 y.o. female with Alzheimer, hyperlipidemia and hypertension presents with left shoulder pain and possible dislocation. Per transfer facility they stated they got films that revealed that patient had a shoulder dislocation brought her into the ER evaluation . Further review revealed X-ray shoulder 2+ view left .Findings: No fracture or dislocation of the left shoulder is seen. Alignment and joint spaces are preserved. Mild glenohumeral and acromioclavicular joint degenerative changes with marginal osteophyte formation. Bones appear demineralized. No erosions or bone destruction. Surrounding soft tissues are unremarkable. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/24/2024 at 10:27 AM with Wound Nurse revealed she was notified by one of the aides but did not remember which aide, that Resident #1 was on the floor on her left side. She stated she remembered reaching out to the doctor and had requested x-rays. She said Resident #1 was able to move everything just fine, Resident #1 was not able to say if she was hurting and the x-ray was to rule out injury and for precaution. She stated she was not there when the x-rays were done. She stated she found the results on Sunday 03/31/2024 and reported it to the DON, family and physician. She stated she thought an agency nurse took over for her on Sunday and that was who she reported it to. Interview and record review on 04/24/2024 at 10:52 AM with LVN G revealed x-ray results were under the clinical tab in [EHR Name]. LVN G stated if she called for a stat x-ray, the results go to [EHR Name] and she would check the results, or the next nurse would. She stated if the previous nurse orders the x-ray, it would be in the 24-hour report which would prompt her to check the results. Interview on 04/24/2024 at 12:36 PM with LVN E revealed she worked for agency and worked at the facility on 03/29/2024. She stated she got the to the facility around 4 PM and relieved the Wound Nurse. She stated the Wound nurse texted her around 8 PM to send the patient to the hospital due to a fall 3 or 4 days prior. She stated the ambulance would not take the patient and told the Wound Nurse to have the DON or Administrator get involved because they would not take the patient. She stated the Wound Nurse told her to get nonemergent transportation scheduled and to inform the family. Interview on 04/24/2024 at 1:04 PM the DON stated she believed Resident #1 fell on [DATE] about 9:30 PM and had an x-ray that day or at 2 AM. When asked when the results were received, the DON stated technically they call the facility to report a critical finding but to her knowledge they did not. She stated she believed she was notified of the results on Sunday (03/31/2024) early morning, and she automatically notified the Administrator and told the Wound Care Nurse who was on the floor to notify the Administrator as well, assess the patient, and continue with neuros. She stated the medical director was notified. The DON stated the physician orders based on the nurse's assessment of where to do the x-rays. She stated a skull series was done for Resident #1 and everything was negative, she went to the hospital and there was no dislocation or fracture. When asked about the findings from the x-ray taken on 03/30/2024 that said dislocation, the DON stated the next steps were to send Resident #1 out to the hospital. The DON stated nurses should receive the results through fax and some are automatically in [EHR NAME] where nurses can go in there to access. The DON stated LVN D did not tell her of any reports because she did reach out to him and did not know if RN C, who worked night shift, missed it. The DON said she did not see it until Sunday morning and her impression was that x-rays were not done. The DON stated the weekend supervisor had left that weekend. She stated when she was notified, she made recommendations to the doctor and Resident #1 received pain medication. Review of facility policy titled Test Results revised April 2007, reflected The resident's Attending Physician will be notified of the results of diagnostic tests. 1. Results of laboratory, radiological, and diagnostic tests shall be reported in writing to the resident's Attending Physician or to the facility. 2. Should the test results be provided to the facility, the Attending Physician shall be promptly notified of the results. 3. The Director of Nursing Services, or Charge Nurse receiving the test results, shall be responsible for notifying the Physician of such test results. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Signed and dated reports of all diagnostic services shall be made a part of the resident's medical record.