STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675904	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

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 - Minimal harm or potential for actual harm 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** 48491 Based on interview and record review the facility failed to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representatives when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention or a significant change in the resident's physical, mental, psychosocial status for 1 (Resident #1) of 6 residents reviewed for notification. The facility failed to ensure Resident #1's resident representative was immediately notified when the resident had a change in condition that required her to be transported via ambulance to the hospital. This failure could result in residents not having the comfort and company of their families during traumatic times. Findings included: Record review of Resident #1's admission record dated 06/30/24 indicated that she was an [AGE] year-old female, who was admitted into the facility on [DATE]. Resident #1 had diagnoses that included but were not limited to: dementia (cognitive loss), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), peripheral vascular disease (blood circulation disorder). Updated diagnoses on 07/03/2024 documented unspecified fracture of unspecified pubis, (hip bone fracture), unspecified fracture of sacrum (pelvis fracture). The admission record further revealed Resident #1's family member was her responsible party and emergency contact. Record review of Resident #1's quarterly MDS completed on 04/16/24. Section C revealed a BIMS of 10 which indicated moderately impaired cognition. Section E indicated Resident #1 had delusions, wandering, verbal behavior toward others. Record review of updated MDS on 06/30/24 indicated a discharge with return anticipated. Section C revealed a BIMS of an 11 which indicated moderately impaired cognition. Resident needed supervision and touching assist with personal needs. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan completed on 07/12/24 revealed resident was a risk for falls related to confusion, deconditioning with gait/balance problems, and being unaware of safety needs with an actual fall with injury on 06/30/24 and required supervision/touching assistance to wheel in wheelchair. Record review of Resident #1's progress note completed by nursing staff, dated 06/30/24 at 01:33 AM revealed Resident #1 had fall with injury when attempting to get up from wheelchair resulting in resident being transported to the hospital for further evaluation. Record review of Resident #1's progress note dated 06/30/24 at 08:21 AM as a late entry and written by nursing staff revealed that resident's family member was notified at 08:21 AM regarding her fall and transfer to hospital. During a telephone interview on 07/16/24 at 08:44 AM, family member stated he was not contacted by the facility when Resident #1 had fallen in the middle of the night. He stated he felt there was a miscommunication because two nurses had thought the other had contacted him. The Family member stated he did not find out until 06/30/24 at 08:21 AM that Resident #1 had fallen and was transferred to the hospital, but that there were extensive apologies from staff and a lot of follow up calls after that. During an interview on 07/16/24 at 11:06 AM, LVN A stated if a resident falls, the protocol was to assess the resident, take vitals, call family, notify nursing supervisors, and notify provider. She stated a possible negative outcome of family not being made aware of a family member falling would be terrible, and if it were her family member, she would want to be notified. During an interview on 07/16/24 at 11:09 AM, RN B stated if a resident falls, the protocol was to assess the resident, take their vitals, assess what might have contributed to the fall, notify family, physician, and nursing supervisor. He stated a possible negative outcome for not calling the family it might take them by surprise especially if the resident had a bad injury resulting from the fall. He stated the family deserve to be in the loop just as much as everybody else. He stated it was a part of the facilities protocol to notify the family immediately. During an interview on 07/16/24 at 11:13 AM, LVN C stated if a resident falls, the protocol was to assess the resident, take vitals, call family, physician, and let nursing supervisors know. She stated if she did not reach the family, she would keep calling them back until she spoke with them, and not just leave a message. She stated the importance of calling the family would be that family members need to know what was going on and that if it were her family, and she was not notified, she would be mad. During an interview on 07/16/24 at 11:15 AM, the DON stated the fall protocol for the facility was to first notify the physician, then notify the family immediately or as soon as possible. She stated the charge nurses are responsible for calling the family and physician. Stated there was a report in the health records that are sent to her when family and physician are contacted, but DON could not find that report of when the family member was called or what time it happened. The DON stated a possible negative outcome for not calling the family was they would be upset. During an interview on 07/16/24 at 11:26 AM, Surveyor requested from DON the facility policy regarding protocol for reporting falls. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/16/24 at 11:35 AM, RN D stated she did not call the family of Resident #1. She stated she was waiting with Resident #1 for the ambulance to arrive and she thought another nurse was going to call the family. She stated she did call the physician and it was her responsibility to call the family but there was a miscommunication, and it did not happen. RN D stated the DON called the family member about 7 or 8 the next morning. She stated a possible negative outcome for not calling the family was that something bad could have happened to Resident #1 and the family would not have known about it. During an interview on 07/16/24 at 11:51 AM, the DON stated they did not have a policy regarding protocol for notification or reporting falls.