STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675905	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Grapevine	1500 Autumn Drive Grapevine, TX 76051

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 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** 41781 Based on observations, interviews, and record review, the facility failed to ensure residents were free from abuse for 1 of 6 residents (Resident #6) reviewed for abuse. The facility failed to ensure Resident #6 had the right to be free from abuse when Resident #7 pushed her on 01/21/25, causing Resident #6 to fall which resulted in a pelvic fracture. An IJ was identified on 03/12/25. The IJ template was provided to the facility on [DATE] at 4:51 PM. While the IJ was removed on 03/13/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure placed residents at risk for abuse. Findings included: Record review of Resident #6's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's significant change in status MDS Assessment, dated 01/29/25, reflected she had a BIMS score of 06, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included unspecified fracture of sacrum (a shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis) and depression. Record review of Resident #6's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #6] had a fall. Was accidentally pushed by another resident. Sent to ER. Record review of Resident #6's Progress Notes reflected the following: 01/21/25 5:36 PM - Resident was pushed to floor by another resident, resident was crying stating her hip hurt, resident was assessed, assisted from floor to dining chair, pain medication administered. DON, MD and RP notified. Stat hip x-ray ordered. Resident is now sittingin [sic] dinning [sic] area, away from other resident eating dinner. Resident stated she has no pain at this time and will let staff know if her hip starts to hurt again. This entry was written by LVN Z. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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F 0600

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

01/21/25 11:11 PM - X-ray performed at this time awaiting for results. This entry was written by LVN Y.

01/22/25 2:15 AM - Result viewed, No acute fracture, dislocation, destructive bony process noted, result will be relayed to MD by incoming nurse. This entry was written by LVN Y.

01/22/25 9:15 AM - Resident has been sent out to [Hospital X] r/t uncontrolled pain (L) hip. Resident is status post fall 1/22/25. STAT Xray result (L) hip shows No Acute Fracture, Dislocation or destructive bony process. Resident c/o pain (L) hip, Tramadol 50mg prn and Tylenol 650mg was administered for pain. Medication was not effective, resident unable to ambulate as she normally does. Notified [the DON] and resident sent out to ER for [NAME] evaluation. [Resident #6's RP] was also notified. This entry was written by LVN W.

01/25/25 12:15 PM - Resident arrived facility [sic] from [Hospital X] by ambulance via stretcher accompanied by [Resident #6's RP] DX open displaced fracture of anterior wall of left acetabulum [an anterior wall acetabular fracture is a break in the front column of bone or area around the bony rim (wall) of your hip socket].Resident [sic] assisted in bed by two nurses, complained of some little pain, tylenol [sic] 650 mg prn given with positive outcome . This entry was written by LVN V.

Record review of Resident #6's hospital records, dated 01/30/25, reflected the following:

As Per admission history and physical dated 1/22/2025

Patient is a 84 y.o. female has a past medical history of Dementia (HCC). admitted after fall at care facility resulting in pelvic fracture and difficulty ambulating. [Resident #6's RP] reports [Resident #6] was previously independent, 'very active' and 'walks on her own'. Recently completed PT at facility and 'checked all the boxes', discharged from therapy last Friday [01/17/25]. Fall mechanism- patient reports being pushed by 'lady' and feeling pain 'from the back'. [Resident #6's RP] unaware of circumstances, states facility noticed fall and difficulty walking.

Hospital Course/Summary:

Ptient [sic] presented after fall unable to bear weight. Found to acute minimally displaced fractures of the anterior left acetabulum, left inferior pubic ramus [describes a type of crack or break in a person's pelvis] and left sacrum .

Record review of Resident #6's Radiology Results Report, dated 01/21/25, reflected: Procedure: HIP UNI W OR W/O PELVIS 2-3 V .INTERPRETATION: Findings: No acute fracture, dislocation or destructive bony process. No soft tissue abnormally. Osteopenia. Mild degenerative changes. Conclusion: No acute osseous abnormality.

Interview on the phone on 02/27/25 at 11:15 AM with Resident #6's RP revealed Resident #6 was pushed by a different resident and her pelvis was fractured as a result. Resident #6's RP said Resident #6 was admitted to the hospital and the fracture did not require screws or any surgery, so the doctor said it was going to heal on its own. Resident #6's RP said before the incident, Resident #6 was able to walk around freely without the use of a walker or wheelchair and now she was no longer mobile, requiring the use of a wheelchair. Resident #6's RP said Resident #6 was able to stand and take some steps, but it hurt the resident and she was not like she was before.

(continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview on 02/27/25 at 11:57 AM with Resident #6 revealed she was sitting in a wheelchair at the nurse's station. Resident #6 said she was not in any pain, had never had a fall, and would never let anyone push her. Resident #6 did not appear to be in any pain. Record review of Resident #7's face sheet, dated 02/27/25, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #7's Quarterly MDS Assessment, dated 01/24/25, reflected she had a BIMS score of 03, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included heart failure, non-Alzheimer's dementia, and depression. Record review of Resident #7's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #7] accidentally pushed another resident to the floor. Education completed, Redirected as needed. Goal: [Resident #7] will not harm self or others through the review date. Interventions/Tasks: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #7's Progress Notes reflected the following entries: 01/21/25 5:25 PM - Resident pushed another resident to the floor, no injuries noted to this resident. Resident was separated from resident she pushed to floor. DON, MD, and RP notified. This entry was written by LVN Z. 01/23/25 4:06 PM - .Patient is seen per staff request due to reports of combativeness, and agitation. Patient is up in the dining area, calm at the moment, and in no distress at this time. She reportedly pushed another resident who sustained injuries, requiringhospitalization [sic]. Patient presents with spontaneous disruptive mood, and combativeness. She is alert to self, and unwilling or unable to participate in the assessment at this time .Chart reviewed, medication profile reviewed .Upon review, based on presenting will further increase Depakote and start patient on Atarax 10 mg twice daily as needed for anxiety. Primary nurse notified, will monitor closely. This entry was written by NP LL. Observation and interview on 02/27/25 at 2:00 PM with Resident #7 revealed she was sitting in a chair at a table with other residents around her. Resident #7 said she was doing good today and did not appear to have any behaviors. (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 02/27/25 at 11:57 AM with LVN Z revealed she was passing medications when Residents #6 and #7 were having an argument and Resident #7 stood up. LVN Z said before she could get to the area where the residents were at, Resident #7 ended up pushing Resident #6. LVN Z said she assessed Resident #6, gave her some pain medication, took her to her room to assess her, and then brought her back to the dining room to eat dinner and everything was fine. LVN Z said she did not see any obvious signs of injuries and Resident #6's pain seemed to be managed. LVN Z said a STAT x-ray was ordered for Resident #6, she notified Resident #6's RP, the DON, the ADON, and the doctor of the incident. LVN Z said during the assessment, there was not any discoloration or bruising to make her think something was injured but the resident did have a slight limp when she pivoted to sit in the chair. LVN Z said before the incident, Resident #6 was completely and independently ambulatory but the next day she was not able to walk so that nurse on shift sent her to the hospital. LVN Z said at the hospital, they found out she had a pelvic fracture. LVN Z said Resident #7 had not been physically aggressive towards other residents before, only combative during care with staff. LVN Z said Resident #7 did get upset though when people were talking around her, thinking that they were talking to her. LVN Z said she knew the Administrator was the abuse coordinator for the facility and that a resident-to-resident altercation that resulted in injuries would be considered abuse. Interview on 02/27/25 at 12:23 PM with CNA V revealed it was around dinner time while staff were serving trays, and Resident #7 was talking to the air and yelling, and some residents were replying back to her. CNA V said they were trying to calm the residents down and telling them to relax when all of a sudden, she saw Resident #7 get up and storm over to push Resident #6 down. CNA V said she went over to stay at Resident #6's side until LVN Z came over. CNA V said after LVN Z took over, she went to check on Resident #7 who was in her room upset but wanted to be left alone. CNA V said Resident #6 looked like she was injured after being pushed because she was shouting and screaming in pain. CNA V said before the incident occurred, Resident #6 was up and walking around and did not need a wheelchair or walker. CNA V said Resident #7 did not have any physically aggressive behaviors before this incident. CNA V said she knew to report abuse to the Administrator who was the abuse coordinator for the facility. Interview on 02/27/25 at 2:36 PM with the DON revealed he received a report that Resident #6 had a fall and then the resident complained of pain and was sent to the ER. The DON said that another resident (Resident #7) had pushed Resident #6 and she fell . The DON said Resident #6 had a pelvic fracture. The DON said he was notified immediately after it happened and when Resident #6 was sent to the ER. The DON said Resident #7 was a little feisty with staff during care but had never attacked another resident. The DON said he was not sure what happened to make Resident #7 push Resident #6 but that it was an accident and was not intentional. The DON said he talked to Resident #7, and she did not mean to hurt anyone, but a resident-to-resident altercation was considered abuse. The DON said he would have to ask the Administrator if she reported the situation or not. The DON said all residents had the right to be free from abuse and all staff were responsible for making sure residents were free from abuse. The DON said Resident #6 was harmed from the situation because she suffered a pelvic fracture and now required the use of a wheelchair. The DON said Resident #6 was independently ambulatory before the incident. (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 02/27/25 at 3:03 PM with the Administrator revealed what she understood was the situation happened in the hallway, LVN Z was standing there and talking with Resident #6 when Resident #7 walked past and bumped her, causing Resident #6 to fall and sustained a fracture. The Administrator said when she spoke to the staff about it, she did not get the impression that it was intentional. The Administrator said Resident #6 was able to ambulate independently before the incident and since the fracture occurred she now used a wheelchair. The Administrator said she did not complete an investigation into what happened because of what she was told by the staff. The Administrator said she only talked to LVN Z about the incident but was not aware she did not see what had happened. The Administrator said she did not speak with CNA V who witnessed the incident between the two residents. The Administrator said she only knew that Resident #6 had a fall, and an x-ray was ordered which had negative results, but she was still complaining of pain. The Administrator said since she was still complaining of pain the facility sent her to the ER and that was when they found out about the fracture. The Administrator said if LVN Z documented that Resident #7 pushed Resident #6 then that was intentional and had a different connotation than an accidental bumping into each other. The Administrator said with the new information regarding the situation, it was considered abuse between two residents. The Administrator said she would have wanted staff to report the incident to her immediately. The Administrator said if she had known the details of the incident, she would have reported it to HHSC. The Administrator said all residents had the right to be free from abuse, even from other residents. The Administrator said everyone was responsible for making sure residents were free from abuse. The Administrator said the purpose of keeping residents safe from abuse was to ensure their continued health and safety. Interview on 03/12/25 at 1:08 PM with LVN W revealed while he did not directly work with Resident #7, he worked on the secured unit and was familiar with her. LVN W said he had never seen or heard about Resident #7 being physically aggressive towards a resident prior to the 01/21/25 incident. LVN W said if Resident #7 started to get agitated he would try to calm her down by redirecting her away from the area or removing the other residents from the area. LVN W said he had been in-serviced on the facility's abuse policy and knew that a resident-to-resident altercation was considered abuse. Interview on 03/12/25 at 1:28 PM with CNA Q revealed while she did not directly work with Resident #7, she worked on the secured unit and was familiar with her. CNA Q said she had never seen or heard about Resident #7 being physically aggressive towards a resident. CNA Q said when Resident #7 started to get agitated she would try to calm her down by redirecting her away from the area or removing the other residents from the area. CNA Q said she had been in-serviced on the facility's abuse policy and knew that a resident-to-resident altercation was considered abuse. Interview on the phone on 03/12/25 at 1:40 PM with RN R revealed she cared for Resident #7 before and knew that sometimes she would get aggressive towards others by yelling at them. RN R said when Resident #7 started to get agitated she would try to calm her down by redirecting her away from the area or removing the other residents from the area. RN R said she had been in-serviced on the facility's abuse policy and knew that a resident-to-resident altercation was considered abuse. Interview on the phone on 03/12/25 at 1:54 PM with CNA S revealed she cared for Resident #7 and knew she had behaviors of yelling at others. CNA S said she had not seen Resident #7 be physically aggressive towards anyone at the facility. CNA S said when Resident #7 started to get agitated she would try to calm her down by redirecting her away from the area or removing the other residents from the area. CNA S said she had been in-serviced on the facility's abuse policy and knew that a resident-to-resident altercation was considered abuse. (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 03/12/25 at 2:00 PM with RA T revealed she cared for Resident #7 and knew that she had behaviors of yelling at others. RA T said she had not seen Resident #7 be physically aggressive towards anyone at the facility. RA T said when Resident #7 started to get agitated she would try to calm her down by redirecting her away from the area or removing the other residents from the area. RA T said she had been in-serviced on the facility's abuse policy and knew that a resident-to-resident altercation was considered abuse. Record review of the facility's Course Completion History report from 09/12/24 to 03/12/25 regarding Abuse, Neglect, and Exploitation Training reflected the following: LVN Z had completed the trainings on 11/30/24 and 02/2/25; CNA V had completed the training on 02/11/25. Record review of the facility's incidents/accidents report from 11/27/24 to 02/27/25 reflected there were no other situations that involved Resident #6 or Resident #7. Record review of the facility's policy, revised September 2022, and titled Identifying Types of Abuse reflected: 1. Abuse of any kind against residents is strictly prohibited .4. 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .5. Abuse toward a resident can occur as: a. resident-to-resident abuse . An IJ was identified on 03/12/25. The IJ template was provided to the facility on [DATE] at 4:51 PM. While the IJ was removed on 03/13/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 03/13/25 at 9:45 AM and reflected the following: .F600 Plan of Removal 03/12/2025 Immediate Corrective Action for residents affected by the alleged deficient practice: On 01/21/25 resident #7 was noted to be walking towards her room, at this time she pushed past resident #6 who fell to the ground. Residents were separated by the nurse and redirected. At this time the staff assisted resident #6 up and assessed her, she was medicated for pain. Stat X-rays were called, initial series was negative for fracture. Upon further complaints of pain, the resident was sent to the hospital for additional imaging. The DON, MD, and daughter were notified. These revealed a pelvic fracture for which no surgery was necessary. Resident #6 returned to the facility with no additional injuries noted. Actions taken to prevent a serious adverse outcome from recurring: This alleged deficient practice had the potential to affect all residents who reside in the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The medical director was notified of the IJ by assistant director of nursing. On 01/21/2025 MDS nurse care planned a new behavior of aggressiveness towards other residents. With interventions of a psych consult and redirection when agitated, this has not been displayed since the initial incident. Staff will be able to identify this behavior and de-escalation techniques in the future based on the resident's care plan and Kardex. Education on de-escalation techniques will be provided to all staff. A psychiatric consult was called by the medical director for resident #7 to review medications and behaviors, this was completed the next day on 01/22/2025. On 03/12/2025 the Administrator and Director of Nursing were educated on abuse and neglect, resident to resident altercations, and de-escalation of resident behaviors. This was done by the VP of Clinical Operations. Staff were previously trained on abuse and neglect as well as de-escalation of resident behaviors in December, by the administrator and DON and through [facility training software] in January and February. We will continue to educate new staff as they are hired. New educations on abuse and neglect, resident to resident altercations, and de-escalation of resident behaviors were started on 03/12/2025. These were implemented by the DON and the administrator; all staff will be educated prior to the start of their next shift. An Ad Hoc QAPI meeting was held on 03/12/2025 to inform all the management team. The DON and ADON will review resident behaviors daily in morning clinical meetings while viewing the 24-hour report/EMR and then weekly in IDT. This will be monitored monthly in QAPI. When Actions will be complete: The [Facility Name] will have completed staff education by 03/13/2025, if any staff member working in the facility is unable to be educated, they will be removed from the schedule until training has been provided. The [Facility Name] requests the removal of the immediate jeopardy on 03/12/2025. Monitoring of the facility's Plan of Removal included the following: Interviews with the following staff from 03/13/25 at 9:46 AM to 2:04 PM who worked all shifts and all days of the week revealed they had been in-serviced on de-escalation techniques for when a resident has aggressive behaviors towards another resident, abuse and neglect, and resident-to-resident altercations: LVN D, LVN G, LVN U, CNA BB, CNA CC, CNA DD, RA EE, CNA FF, CNA GG, CNA HH, CNA II, MA JJ, RN KK, LVN W, CNA V, CNA Q, CNA M, RA T, the ADON, the DON, and the Administrator. Record review of an in-service sign in sheet, dated 03/12/25, and titled Resident to Resident Abuse reflected 52 staff had been in-serviced. (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 an Ad Hoc QAPI Agenda, dated 03/12/25, reflected all IDT members were in attendance. Record review of an in-service sign in sheets, dated 03/12/25, and titled Abuse, Neglect, and Misappropriation Policy and Redirection of a resident that is becoming combative with others, reflected both the DON and Administrator had signed. An IJ was identified on 03/12/25. The IJ template was provided to the facility on [DATE] at 4:51 PM. While the IJ was removed on 03/13/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of property for 1 of 8 residents (Resident #12) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #12's debit card when it was taken by CNA I. The noncompliance was identified as past noncompliance. The noncompliance began on 09/18/24 and ended on 09/18/24. The facility had corrected the noncompliance before the abbreviated survey began. This failure could place residents at risk of misappropriation of property. Findings included: Record review of Resident #12's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included diabetes, multiple sclerosis (a chronic autoimmune disease that affects the central nervous system), and anxiety disorder. The resident had a BIMS score of 14 which indicated her cognition was intact. Record review of the facility's Provider Investigation Report dated 09/26/24 reflected the following: [Resident #12's] [family] called to report the resident's debit card stolen and it had been used at three locations in [city] [business] - $54.00 [business] - $157.00 [business] - $48.00 On 09/18/24 the photos from the [business] were sent to the administrator. The DON identified the staff member [CNA I] At the time [CNA I] was suspended and when asked to provide a statement did not [CNA I] has been terminated, the staff have been educated on abuse, neglect, and misappropriation. Interview on 02/27/25 at 11:18 AM with Resident #12 revealed she was in her room in her wheelchair. The resident said her [family] had called her and asked if she had her debit card because it appeared it had been used at several businesses. Resident #12 said she usually kept her card in her purse in the top drawer of her night stand and when she went to look for it, it was not there and there was also $20 missing from her purse. The resident also said it appeared to have been a new staff member that had not worked at the facility long and the day after the incident, a police officer had gone to talk to her about the theft. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/28/25 at 1:49 PM with Resident #12's family revealed the resident had a fanny pack in the drawer of her night stand where she kept some of her personal belongings. The family said they noticed there were some charges at three businesses that appeared to be suspicious. so He called the facility so they could check if her debit card was still in the resident's possession, and they noticed it was gone. One of the businesses were able to share their camera footage where the facility management was able to recognize CNA I as the one who had taken and used the debit card. The family also said the debit card was frozen and he pressed charges in hopes that it would not happen to anyone else. Interview on 02/28/25 at 2:28 PM with the Social Worker revealed she had been made aware a staff member had taken and used Resident #12's debit card. She said she did not participate in the investigation but had interviewed other alert and oriented residents to ensure there were no other missing personal belongings and there were no other concerns noted. Interview on 02/28/25 at 2:49 PM with the ADON revealed she had been made aware by the Administrator that CNA I had taken Resident #12's debit card and used it because they had recognized her in the business video footage. The ADON said CNA I was new to the facility and had only worked at the facility for about two weeks. The ADON further stated she was responsible for in-servicing the staff on abuse, neglect, and misappropriation. Interview on 02/28/25 at 3:11 PM with the Administrator revealed Resident #12's family called the facility and asked if someone could check the resident's purse to see if her debit card was in there. The staff went to go look and they were not able to find it anywhere in the resident's room. The family made her aware there had been some fraudulent charges made to the account, so they began their investigation. The Administrator said they had checked the facility camera footage to see what staff had entered the room that day and when the business shared their video footage, they were able to recognize CNA I as the staff member who had used the stolen card. CNA I was called and asked to give a statement, but she refused and denied the allegations even after she was told she had been identified in the business footage. CNA I was terminated, and the rest of the facility staff were re-in-serviced on abuse, neglect, and misappropriation. Interviews with other residents revealed there were no other concerns with misappropriation. Attempts to interview CNA I on 02/28/25 were unsuccessful as the phone number was no longer active. Record review of the facility's policy titled Identifying Exploitation, Theft, and Misappropriation of Resident Property dated April 2021 reflected the following: .1. Exploitation, theft, and misappropriation of resident property are strictly prohibited .4. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent Record review of the facility's in-service titled Abuse; Identifying Exploitation, Theft, Misappropriation dated 09/18/24 revealed 25 staff members participated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Grapevine	1500 Autumn Drive Grapevine, TX 76051

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/28/25 from 9:53 PM to 2:49 PM with the ADON, LVN B, Activity Director, Housekeeper J, Housekeeper K, Floor Tech, MA L, Restorative Aide, CNA M, CNA N, CNA O, CNA P, LVN D, LVN E, RN F, LVN G, and LVN H revealed they were in-serviced on the types on abuse, neglect, and misappropriation. All staff were able to name the different types of abuse, define misappropriation, and to report any type of abuse to the Administrator who was the abuse coordinator. Record review of CNA I's personnel file revealed she was terminated on 09/18/24 for theft of Resident #12's debit card. Interview on 02/27/25 and 02/28/25 with 12 alert and oriented residents revealed they did not have any concerns/issues with theft or misappropriation.

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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 0607 Level of Harm - Minimal harm or potential for actual harm 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** 41781 Based on observation, interview, and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse and misappropriation for 1 of 2 incidents (Resident #6) reviewed for reporting. 1. The facility failed to implement its policy by ensuring LVN Z and CNA V reported an incident of resident-to-resident abuse immediately to the Administrator, who was the Abuse Coordinator, on 01/21/25 when Resident #7 pushed Resident #6, causing her to fall and sustain a pelvic fracture. 2. The Administrator failed to investigate an incident of abuse when Resident #6 was pushed by Resident #7 on 01/21/25 and sustained a pelvic fracture. 3. The Administrator failed to report to HHSC when Resident #7 pushed Resident #6 causing Resident #6 to sustain a pelvic fracture. This failure could place the residents in the facility at risk of continued abuse. Findings included: Record review of the facility's Identifying Types of Abuse policy, revised September 2022, reflected: 1. Abuse of any kind against residents is strictly prohibited .4. 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . 5. Abuse toward a resident can occur as: a. resident-to-resident abuse . Record review of the facility's Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, revised September 2022, reflected: Policy statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation; Reporting Allegations to the Administrator and Authorities, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . Record review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, revised April 2021, reflected: Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to freedom of corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents; .2. Develop and implement policies and procedures to prevent and identify: a. abuse or mistreatment of residents . (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's significant change in status MDS Assessment, dated 01/29/25, reflected she had a BIMS score of 06, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included unspecified fracture of sacrum and depression. Record review of Resident #6's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #6] had a fall. Was accidentally pushed by another resident. Sent to ER. Record review of Resident #6's Progress Notes reflected the following: 01/21/25 5:36 PM - Resident was pushed to floor by another resident, resident was crying stating her hip hurt, resident was assessed, assisted from floor to dining chair, pain medication administered. DON, MD and RP notified. Stat hip x-ray ordered. Resident is now sittingin [sic] dinning [sic] area, away from other resident eating dinner. Resident stated she has no pain at this time and will let staff know if her hip starts to hurt again. This entry was written by LVN Z. 01/21/25 11:11 PM - X-ray performed at this time awaiting for results. This entry was written by LVN Y. 01/22/25 2:15 AM - Result viewed, No acute fracture, dislocation, destructive bony process noted, result will be relayed to MD by incoming nurse. This entry was written by LVN Y. 01/22/25 9:15 AM - Resident has been sent out to [Hospital X] r/t uncontrolled pain (L) hip. Resident is status post fall 1/22/25. STAT Xray result (L) hip shows No Acute Fracture, Dislocation or destructive bony process. Resident c/o pain (L) hip, Tramadol 50mg prn and Tylenol 650mg was administered for pain. Medication was not effective, resident unable to ambulate as she normally does. Notified [the DON] and resident sent out to ER for [NAME] evaluation. [Resident #6's RP] was also notified. This entry was written by LVN W. 01/25/25 12:15 PM - Resident arrived facility [sic] from [Hospital X] by ambulance via stretcher accompanied by [Resident #6's RP] DX open displaced fracture of anterior wall of left acetabulum [an anterior wall acetabular fracture is a break in the front column of bone or area around the bony rim (wall) of your hip socket].Resident [sic] assisted in bed by two nurses, complained of some little pain, tylenol [sic] 650 mg prn given with positive outcome . This entry was written by LVN V. Record review of Resident #6's hospital records, dated 01/30/25, reflected the following: As Per admission history and physical dated 1/22/2025 Patient is a 84 y.o. female has a past medical history of Dementia (HCC). admitted after fall at care facility resulting in pelvic fracture and difficulty ambulating. [Resident #6's RP] reports [Resident #6] was previously independent, 'very active' and 'walks on her own'. Recently completed PT at facility and 'checked all the boxes', discharged from therapy last Friday [01/17/25]. Fall mechanism- patient reports being pushed by 'lady' and feeling pain 'from the back'. [Resident #6's RP] unaware of circumstances, states facility noticed fall and difficulty walking. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 Autumn Drive Grapevine, TX 76051	

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital Course/Summary: Ptient [sic] presented after fall unable to bear weight. Found to acute minimally displaced fractures of the anterior left acetabulum, left inferior pubic ramus [describes a type of crack or break in a person's pelvis] and left sacrum . Record review of Resident #6's Radiology Results Report, dated 01/21/25, reflected: Procedure: HIP UNI W OR W/O PELVIS 2-3 V .INTERPRETATION: Findings: No acute fracture, dislocation or destructive bony process. No soft tissue abnormally. Osteopenia. Mild degenerative changes. Conclusion: No acute osseous abnormality. Interview on the phone on 02/27/25 at 11:15 AM with Resident #6's RP revealed Resident #6 was pushed by a different resident, and her pelvis was fractured as a result. Resident #6's RP said Resident #6 was admitted to the hospital. The RP stated the fracture did not require screws or any surgery, so the doctor said it was going to heal on its own. Resident #6's RP said before the incident, Resident #6 was able to walk around freely without the use of a walker or wheelchair, and now she was no longer mobile, requiring the use of a wheelchair. Resident #6's RP said Resident #6 was able to stand and take some steps, but it hurt the resident. She stated Resident #6 was not like she was before. Observation and interview on 02/27/25 at 11:57 AM with Resident #6 revealed she was sitting in a wheelchair at the nurses' station. Resident #6 said she was not in any pain, had never had a fall, and would never let anyone push her. Resident #6 did not appear to be in any pain. Record review of Resident #7's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #7's Quarterly MDS Assessment, dated 01/24/25, reflected she had a BIMS score of 03, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included heart failure, non-alzheimer's dementia, and depression. Record review of Resident #7's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #7] accidentally pushed another resident to the floor. Education completed, Redirected as needed. Goal: [Resident #7] will not harm self or others through the review date. Interventions/Tasks: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #7's Progress Notes reflected the following: 01/21/25 5:25 PM - Resident pushed another resident to the floor, no injuries noted to this resident. Resident was separated from resident she pushed to floor. DON, MD, and RP notified. This entry was written by LVN Z. (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

01/23/25 4:06 PM - .Patient is seen per staff request due to reports of combativeness, and agitation. Patient is up in the dining area, calm at the moment, and in no distress at this time. She reportedly pushed another resident who sustained injuries, requiringhospitalization [sic]. Patient presents with spontaneous disruptive mood, and combativeness. She is alert to self, and unwilling or unable to participate in the assessment at this time .Chart reviewed, medication profile reviewed .Upon review, based on presenting will further increase Depakote and start patient on Atarax 10 mg twice daily as needed for anxiety. Primary nurse notified, will monitor closely. This entry was written by NP LL.

Interview on 02/27/25 at 11:57 AM with LVN Z revealed she was passing medications when Residents #6 and #7 were having an argument, and Resident #7 stood up. LVN Z said before she could get to the area where the residents were at, Resident #7 ended up pushing Resident #6. LVN Z said she assessed Resident #6, gave her some pain medication, took her to her room to assess her, and then brought her back to the dining room to eat dinner and everything was fine. LVN Z said she did not see any obvious signs of injuries and Resident #6's pain seemed to be managed. LVN Z said a STAT x-ray was ordered for Resident #6, she notified Resident #6's RP, the DON, ADON, and the doctor of the incident. LVN Z said during the assessment, there was not any discoloration or bruising to make her think something was injured but the resident did have a slight limp when she pivoted to sit in the chair. LVN Z said before the incident, Resident #6 was completely and independently ambulatory, but the next day she was not able to walk so that nurse on shift sent her to the hospital. LVN Z said at the hospital, they found out she had a pelvic fracture. LVN Z said Resident #7 has not been physically aggressive towards other residents before, only combative during care with staff. LVN Z said Resident #7 did get upset though when people were talking around her, thinking they were talking to her. LVN Z said she knew the Administrator was the Abuse Coordinator for the facility and that a resident-to-resident altercation that resulted in injuries would be considered abuse. LVN Z said she would report that situation to the Administrator, but she did not think it was abuse at the time so she did not immediately report the situation. LVN Z said because Resident #7 had dementia and was very confused, she did not think it would be considered abuse at the time.

Interview on 02/27/25 at 12:23 PM with CNA V revealed it was around dinner time while staff were serving trays, and Resident #7 was talking to the air and yelling and some residents were replying back to her. CNA V said they were trying to calm the residents down and telling them to relax. CNA V said all of a sudden, she saw Resident #7 get up and storms over to push Resident #6 down. CNA V said she went over to stay at Resident #6's side until LVN Z came over. CNA V said after LVN Z took over, she went to check on Resident #7 who was in her room upset but wanted to be left alone. CNA V said Resident #6 looked like she was injured after being pushed because she was shouting and screaming in pain. CNA V said before the incident occurred, Resident #6 was up and walking around and did not need a wheelchair or walker. CNA V said Resident #7 did not have any physically aggressive behaviors before this incident. CNA V said she knew to report abuse to the Administrator who was the abuse coordinator for the facility. CNA V said she was not sure why she did not report the situation to the Administrator . CNA V said when the situation happened between Residents #6 and #7 she had only been working at the facility for a couple of weeks.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 2:36 PM with the DON revealed he received a report that Resident #6 had a fall and then the resident complained of pain and was sent to the ER. The DON said that another resident (Resident #7) had pushed Resident #6 and she fell . The DON said Resident #6 had a pelvic fracture. The DON said he was notified immediately after it happened and when Resident #6 was sent to the ER. The DON said Resident #7 was a little feisty with staff during care, but she had never attacked another resident. The DON said he was not sure what happened to make Resident #7 push Resident #6, but it was an accident and was not intentional. The DON said he talked to Resident #7, and she did not mean to hurt anyone. The DON said a resident-to-resident altercation was considered abuse. The DON said he would have to ask the Administrator if she reported the situation or not. The DON said all residents had the right to be free from abuse and all staff were responsible for making sure residents were free from abuse. The DON said Resident #6 was harmed from the situation because she suffered a pelvic fracture and now required the use of a wheelchair. The DON said Resident #6 was independently ambulatory before the incident. Interview on 02/27/25 at 3:03 PM with the Administrator revealed what she understood was that the situation happened in the hallway, LVN Z was standing there and talking with Resident #6 when Resident #7 walked past and bumped her, causing Resident #6 to fall and sustained a fracture. The Administrator said when she spoke to the staff about it, she did not get the impression that it was intentional. The Administrator said Resident #6 was able to ambulate independently before the incident and since the fracture occurred she now used a wheelchair. The Administrator said she did not complete an investigation into what happened because of what she was told by the staff. The Administrator said she only talked to LVN Z about the incident but was not aware that she did not see what had happened. The Administrator said she did not speak with CNA V who witnessed the incident between the two residents. The Administrator said she only knew that Resident #6 had a fall and an x-ray was ordered which had negative results but she was still complaining of pain. The Administrator said since she was still complaining of pain the facility sent her to the ER and that was when they found out about the fracture. The Administrator said if LVN Z documented that Resident #7 pushed Resident #6 then that was intentional and has a different connotation than an accidental bumping into each other. The Administrator said with the new information regarding the situation, it was considered abuse between two residents. The Administrator said she would have wanted staff to report the incident to her immediately. The Administrator said if she had known the details of the incident she would have reported it to HHSC. The Administrator said all residents had the right to be free from abuse, even from other residents. The Administrator said everyone was responsible for making sure that residents were free from abuse. The Administrator said the purpose of keeping residents safe from abuse was to ensure their continued health and safety. The Administrator said all staff were responsible for reporting abuse to her immediately. The Administrator said if staff were not immediately reporting abuse to her then that could pave the way for people to be injured or harmed in some way or for abuse to continue. The Administrator said she expected all staff to follow the facility's abuse policy. The Administrator said she would have completed an investigation into the situation had she known about the details beforehand. The Administrator said her investigation would have included resident records, witness statements, safe surveys, assessments, and education with staff. The Administrator said if there was not an investigation into what happened, there would not be measures in place to make sure residents were safe from abuse. The Administrator said if she did not know what happened she could not fix it. The Administrator said she and the DON would be responsible for completing the investigation together. (continued on next page)

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	675905	A. Building B. Wing	03/13/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Course Completion History report from 09/12/24 to 03/12/25 regarding Abuse, Neglect, and Exploitation Training reflected the following: LVN Z had completed the trainings on 11/30/24 and 02/2/25; CNA V had completed the training on 02/11/25.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observation, interview, and record review the facility failed to ensure all alleged violations involving abuse were immediately report, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the Administrator of the facility and to other officials including the State Survey Agency (HHSC) in a timely manner for 1 of 3 residents (Resident #6) reviewed for abuse. 1. LVN Z and CNA V failed to report an incident of resident-to-resident abuse immediately to the Administrator, who was the Abuse Coordinator, on 01/21/25 when Resident #7 pushed Resident #6, causing her to fall and sustain a pelvic fracture. 2. The Administrator failed to report to HHSC within 2 hours of Resident #6 being pushed by Resident #6 causing her to sustain a pelvic fracture. The failure could place residents at risk of serious harm or neglect. Findings included: Record review of Resident #6's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's significant change in status MDS Assessment, dated 01/29/25, reflected she had a BIMS score of 06, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included unspecified fracture of sacrum and depression. Record review of Resident #6's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #6] had a fall. Was accidentally pushed by another resident. Sent to ER. Record review of Resident #6's Progress Notes reflected the following: -Resident was pushed to floor by another resident, resident was crying stating her hip hurt, resident was assessed, assisted from floor to dining chair, pain medication administered. DON, MD and RP notified. Stat hip x-ray ordered. Resident is now sittingin [sic] dinning [sic] area, away from other resident eating dinner. Resident stated she has no pain at this time and will let staff know if her hip starts to hurt again. Written by LVN Z on 01/21/25 at 5:36 PM. -X-ray performed at this time awaiting for results. Written by LVN Y on 01/21/25 at 11:11 PM. -Result viewed, No acute fracture, dislocation, destructive bony process noted, result will be relayed to MD by incoming nurse. Written by LVN Y on 01/22/25 at 2:15 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident has been sent out to [Hospital X] r/t uncontrolled pain (L) hip. Resident is status post fall 1/22/25. STAT Xray result (L) hip shows No Acute Fracture, Dislocation or destructive bony process. Resident c/o pain (L) hip, Tramadol 50mg prn and Tylenol 650mg was administered for pain. Medication was not effective, resident unable to ambulate as she normally does. Notified [the DON] and resident sent out to ER for [NAME] evaluation. [Resident #6's RP] was also notified. Written by LVN W on 01/22/25 at 9:15 AM. -Resident arrived facility [sic] from [Hospital X] by ambulance via stretcher accompanied by [Resident #6's RP] DX open displaced fracture of anterior wall of left acetabulum [an anterior wall acetabular fracture is a break in the front column of bone or area around the bony rim (wall) of your hip socket].Resident [sic] assisted in bed by two nurses, complained of some little pain ,tylenol [sic] 650 mg prn given with positive outcome . Written by LVN V on 01/25/25 at 12:15 PM. Record review of Resident #6's hospital records, dated 01/30/25, reflected the following: As Per admission history and physical dated 1/22/2025 Patient is a 84 y.o. female has a past medical history of Dementia (HCC). admitted after fall at care facility resulting in pelvic fracture and difficulty ambulating. [Resident #6's RP] reports [Resident #6] was previously independent, 'very active' and 'walks on her own'. Recently completed PT at facility and 'checked all the boxes', discharged from therapy last Friday [01/17/25]. Fall mechanism- patient reports being pushed by 'lady' and feeling pain 'from the back'. [Resident #6's RP] unaware of circumstances, states facility noticed fall and difficulty walking. Hospital Course/Summary: Ptient [sic] presented after fall unable to bear weight. Found to acute minimally displaced fractures of the anterior left acetabulum, left inferior pubic ramus [describes a type of crack or break in a person's pelvis] and left sacrum . Record review of Resident #6's Radiology Results Report, dated 01/21/25, reflected: Procedure: HIP UNI W OR W/O PELVIS 2-3 V .INTERPRETATION: Findings: No acute fracture, dislocation or destructive bony process. No soft tissue abnormally. Osteopenia. Mild degenerative changes. Conclusion: No acute osseous abnormality. Interview on the phone on 02/27/25 at 11:15 AM with Resident #6's RP revealed Resident #6 was pushed by a different resident and her pelvis was fractured as a result. Resident #6's RP said Resident #6 was admitted to the hospital and the fracture did not require screws or any surgery so the doctor said it was going to heal on it's own. Resident #6's RP said before the incident, Resident #6 was able to walk around freely without the use of a walker or wheelchair and now she is no longer mobile, requiring the use of a wheelchair. Resident #6's RP said Resident #6 was able to stand and take some steps but it hurt the resident and was not like she was before. Observation and interview on 02/27/25 at 11:57 AM with Resident #6 revealed she was sitting in a wheelchair at the nurse's station. Resident #6 said she was not in any pain, had never had a fall, and would never let anyone push her. Resident #6 did not appear to be in any pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's face sheet, dated 02/27/25, reflected she was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #7's Quarterly MDS Assessment, dated 01/24/25, reflected she had a BIMS score of 03, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included heart failure, non-alzheimer's dementia, and depression. Record review of Resident #7's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #7] accidentally pushed another resident to the floor. Education completed, Redirected as needed. Goal: [Resident #7] will not harm self or others through the review date. Interventions/Tasks: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #7's Progress Notes reflected the following: -Resident pushed another resident to the floor, no injuries noted to this resident. Resident was separated from resident she pushed to floor. DON, MD, and RP notified. Written by LVN Z on 01/21/25 at 5:25 PM. - .Patient is seen per staff request due to reports of combativeness, and agitation. Patient is up in the dining area, calm at the moment, and in no distress at this time. She reportedly pushed another resident who sustained injuries, requiringhospitalization [sic]. Patient presents with spontaneous disruptive mood, and combativeness. She is alert to self, and unwilling or unable to participate in the assessment at this time . Chart reviewed, medication profile reviewed .Upon review, based on presenting will further increase Depakote and start patient on Atarax 10 mg twice daily as needed for anxiety. Primary nurse notified, will monitor closely. Written by NP LL on 01/23/25 at 4:06 PM Observation and interview on 02/27/25 at 2:00 PM with Resident #7 revealed she was sitting in a chair at a table with other residents around her. Resident #7 said she was doing good today and did not appear to have any behaviors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 11:57 AM with LVN Z revealed she was passing medications when Residents #6 and #7 were having an argument and Resident #7 stood up. LVN Z said before she could get to the area where the residents were at, Resident #7 ended up pushing Resident #6. LVN Z said she assessed Resident #6, gave her some pain medication, took her to her room to assess her, and then brought her back to the dining room to eat dinner and everything was fine. LVN Z said she did not see any obvious signs of injuries and Resident #6's pain seemed to be managed. LVN Z said a STAT x-ray was ordered for Resident #6, she notified Resident #6's RP, the DON, ADON, and the doctor of the incident. LVN Z said during the assessment, there was not any discoloration or bruising to make her think something was injured but the resident did have a slight limp when she pivoted to sit in the chair. LVN Z said before the incident, Resident #6 was completely and independently ambulatory but the next day she was not able to walk so that nurse on shift sent her to the hospital. LVN Z said at the hospital, they found out she had a pelvic fracture. LVN Z said Resident #7 has not been physically aggressive towards other residents before, only combative during care with staff. LVN Z said Resident #7 does get upset though when people were talking around her, thinking that they were talking to her. LVN Z said she knew the Administrator was the abuse coordinator for the facility and that a resident-to-resident altercation that resulted in injuries would be considered abuse. LVN Z said she would report that situation to the Administrator but did not think it was abuse at the time so she did not immediately report the situation. LVN Z said because Resident #7 had dementia and was very confused she did not think it would be considered abuse at the time. Interview on 02/27/25 at 12:23 PM with CNA V revealed it was around dinner time while staff were serving trays, and Resident #7 was talking to the air and yelling and some residents were replying back to her. CNA V said they were trying to calm the residents down and telling them to relax. CNA V said all of a sudden, she saw Resident #7 get up and storms over to push Resident #6 down. CNA V said she went over to stay at Resident #6's side until LVN Z came over. CNA V said after LVN Z took over, she went to check on Resident #7 who was in her room upset but wanted to be left alone. CNA V said Resident #6 looked like she was injured after being pushed because she was shouting and screaming in pain. CNA V said before the incident occurred, Resident #6 was up and walking around and did not need a wheelchair or walker. CNA V said Resident #7 did not have any physically aggressive behaviors before this incident. CNA V said she knew to report abuse to the Administrator who was the abuse coordinator for the facility. CNA V said she was not sure why she did not report the situation to the Administrator. Interview on 02/27/25 at 2:36 PM with the DON revealed he received a report that Resident #6 had a fall and then the resident complained of pain and was sent to the ER. The DON said that another resident (Resident #7) had pushed Resident #6 and she fell . The DON said Resident #6 had a pelvic fracture. The DON said he was notified immediately after it happened and when Resident #6 was sent to the ER. The DON said Resident #7 was a little feisty with staff during care but has never attacked another resident. The DON said he was not sure what happened to make Resident #7 push Resident #6 but that it was an accident and was not intentional. The DON said he talked to Resident #7 and she did not mean to hurt anyone, but a resident-to-resident altercation was considered abuse. The DON said he would have to ask the Administrator if she reported the situation or not. The DON said all residents had the right to be free from abuse and all staff were responsible for making sure residents were free from abuse. The DON said Resident #6 was harmed from the situation because she suffered a pelvic fracture and now required the use of a wheelchair. The DON said Resident #6 was independently ambulatory before the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 3:03 PM with the Administrator revealed what she understood was that the situation happened in the hallway, LVN Z was standing there and talking with Resident #6 when Resident #7 walked past and bumped her, causing Resident #6 to fall and sustained a fracture. The Administrator said when she spoke to the staff about it, she did not get the impression that it was intentional. The Administrator said Resident #6 was able to ambulate independently before the incident and since the fracture occurred she now used a wheelchair. The Administrator said she did not complete an investigation into what happened because of what she was told by the staff. The Administrator said she only talked to LVN Z about the incident but was not aware that she did not see what had happened. The Administrator said she did not speak with CNA V who witnessed the incident between the two residents. The Administrator said she only knew that Resident #6 had a fall and an x-ray was ordered which had negative results but she was still complaining of pain. The Administrator said since she was still complaining of pain the facility sent her to the ER and that was when they found out about the fracture. The Administrator said if LVN Z documented that Resident #7 pushed Resident #6 then that was intentional and has a different connotation than an accidental bumping into each other. The Administrator said with the new information regarding the situation, it was considered abuse between two residents. The Administrator said she would have wanted staff to report the incident to her immediately. The Administrator said if she had known the details of the incident she would have reported it to HHSC. The Administrator said all residents have the right to be free from abuse, even from other residents. The Administrator said everyone was responsible for making sure that residents were free from abuse. The Administrator said the purpose of keeping residents safe from abuse was to ensure their continued health and safety. The Administrator said all staff were responsible for reporting abuse to her immediately. The Administrator said if staff were not immediately reporting abuse to her then that could pave the way for people to be injured or harmed in some way or for abuse to continue. The Administrator said she expected all staff to follow the facility's abuse policy. The Administrator said she would have completed an investigation into the situation had she known about the details beforehand. The Administrator said her investigation would have included resident records, witness statements, safe surveys, assessments, and education with staff. The Administrator said if there was not an investigation into what happened, there would not be measures in place to make sure residents were safe from abuse. The Administrator said if she did not know what happened she could not fix it. The Administrator said she and the DON would be responsible for completing the investigation together. Record review of the facility's policy, revised September 2022, and titled Identifying Types of Abuse reflected: 1. Abuse of any kind against residents is strictly prohibited .4. 'Abuse' is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .5. Abuse toward a resident can occur as: a. resident-to-resident abuse . Record review of the facility's policy, revised September 2022, and titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating reflected: Policy statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation; Reporting Allegations to the Administrator and Authorities, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy, revised April 2021, and titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program reflected: Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to freedom of corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; b. other residents; .2. Develop and implement policies and procedures to prevent and identify: a. abuse or mistreatment of residents . Record review of the facility's Course Completion History report from 09/12/24 to 03/12/25 regarding Abuse, Neglect, and Exploitation Training reflected the following: LVN Z had completed the trainings on 11/30/24 and 02/2/25; CNA V had completed the training on 02/11/25.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41781 Based on observations, interviews, and record review the facility failed to investigate and report an allegation of abuse for 1 of 3 residents (Resident #6) reviewed for abuse allegations. The Administrator failed to investigate an incident of abuse when Resident #6 was pushed by Resident #7 on 01/21/25 and sustained a pelvic fracture. This failure could place residents at risk of harm and injuries related to abuse and a delay in investigating. Findings included: Record review of Resident #6's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #6's significant change in status MDS Assessment, dated 01/29/25, reflected she had a BIMS score of 06, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included unspecified fracture of sacrum and depression. Record review of Resident #6's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #6] had a fall. Was accidentally pushed by another resident. Sent to ER. Record review of Resident #6's Progress Notes reflected the following: -Resident was pushed to floor by another resident, resident was crying stating her hip hurt, resident was assessed, assisted from floor to dining chair, pain medication administered. DON, MD and RP notified. Stat hip x-ray ordered. Resident is now sittingin [sic] dinning [sic] area, away from other resident eating dinner. Resident stated she has no pain at this time and will let staff know if her hip starts to hurt again. Written by LVN Z on 01/21/25 at 5:36 PM. -X-ray performed at this time awaiting for results. Written by LVN Y on 01/21/25 at 11:11 PM. -Result viewed, No acute fracture, dislocation, destructive bony process noted, result will be relayed to MD by incoming nurse. Written by LVN Y on 01/22/25 at 2:15 AM. -Resident has been sent out to [Hospital X] r/t uncontrolled pain (L) hip. Resident is status post fall 1/22/25. STAT Xray result (L) hip shows No Acute Fracture, Dislocation or destructive bony process. Resident c/o pain (L) hip, Tramadol 50mg prn and Tylenol 650mg was administered for pain. Medication was not effective, resident unable to ambulate as she normally does. Notified [the DON] and resident sent out to ER for [NAME] evaluation. [Resident #6's RP] was also notified. Written by LVN W on 01/22/25 at 9:15 AM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident arrived facility [sic] from [Hospital X] by ambulance via stretcher accompanied by [Resident #6's RP] DX open displaced fracture of anterior wall of left acetabulum [an anterior wall acetabular fracture is a break in the front column of bone or area around the bony rim (wall) of your hip socket].Resident [sic] assisted in bed by two nurses, complained of some little pain ,tylenol [sic] 650 mg prn given with positive outcome . Written by LVN V on 01/25/25 at 12:15 PM. Record review of Resident #6's hospital records, dated 01/30/25, reflected the following: As Per admission history and physical dated 1/22/2025 Patient is a 84 y.o. female has a past medical history of Dementia (HCC). admitted after fall at care facility resulting in pelvic fracture and difficulty ambulating. [Resident #6's RP] reports [Resident #6] was previously independent, 'very active' and 'walks on her own'. Recently completed PT at facility and 'checked all the boxes', discharged from therapy last Friday [01/17/25]. Fall mechanism- patient reports being pushed by 'lady' and feeling pain 'from the back'. [Resident #6's RP] unaware of circumstances, states facility noticed fall and difficulty walking. Hospital Course/Summary: Ptient [sic] presented after fall unable to bear weight. Found to acute minimally displaced fractures of the anterior left acetabulum, left inferior pubic ramus [describes a type of crack or break in a person's pelvis] and left sacrum . Record review of Resident #6's Radiology Results Report, dated 01/21/25, reflected: Procedure: HIP UNI W OR W/O PELVIS 2-3 V .INTERPRETATION: Findings: No acute fracture, dislocation or destructive bony process. No soft tissue abnormally. Osteopenia. Mild degenerative changes. Conclusion: No acute osseous abnormality. Interview on the phone on 02/27/25 at 11:15 AM with Resident #6's RP revealed Resident #6 was pushed by a different resident and her pelvis was fractured as a result. Resident #6's RP said Resident #6 was admitted to the hospital and the fracture did not require screws or any surgery so the doctor said it was going to heal on it's own. Resident #6's RP said before the incident, Resident #6 was able to walk around freely without the use of a walker or wheelchair and now she is no longer mobile, requiring the use of a wheelchair. Resident #6's RP said Resident #6 was able to stand and take some steps but it hurt the resident and was not like she was before. Observation and interview on 02/27/25 at 11:57 AM with Resident #6 revealed she was sitting in a wheelchair at the nurse's station. Resident #6 said she was not in any pain, had never had a fall, and would never let anyone push her. Resident #6 did not appear to be in any pain. Record review of Resident #7's face sheet, dated 02/27/25, reflected the resident was an [AGE] year-old female who admitted to the facility on [DATE]. Record review of Resident #7's Quarterly MDS Assessment, dated 01/24/25, reflected she had a BIMS score of 03, indicating severe cognitive impairment. Her MDS indicated she had delusions but no other behaviors. Her diagnoses included heart failure, non-alzheimer's dementia, and depression. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #7's care plan, revised 01/22/25, reflected the following: Focus: 1/21/25- [Resident #7] accidentally pushed another resident to the floor. Education completed, Redirected as needed. Goal: [Resident #7] will not harm self or others through the review date. Interventions/Tasks: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later. Record review of Resident #7's Progress Notes reflected the following: -Resident pushed another resident to the floor, no injuries noted to this resident. Resident was separated from resident she pushed to floor. DON, MD, and RP notified. Written by LVN Z on 01/21/25 at 5:25 PM. - .Patient is seen per staff request due to reports of combativeness, and agitation. Patient is up in the dining area, calm at the moment, and in no distress at this time. She reportedly pushed another resident who sustained injuries, requiringhospitalization [sic]. Patient presents with spontaneous disruptive mood, and combativeness. She is alert to self, and unwilling or unable to participate in the assessment at this time . Chart reviewed, medication profile reviewed .Upon review, based on presenting will further increase Depakote and start patient on Atarax 10 mg twice daily as needed for anxiety. Primary nurse notified, will monitor closely. Written by NP LL on 01/23/25 at 4:06 PM Observation and interview on 02/27/25 at 2:00 PM with Resident #7 revealed she was sitting in a chair at a table with other residents around her. Resident #7 said she was doing good today and did not appear to have any behaviors. Interview on 02/27/25 at 11:57 AM with LVN Z revealed she was passing medications when Residents #6 and #7 were having an argument and Resident #7 stood up. LVN Z said before she could get to the area where the residents were at, Resident #7 ended up pushing Resident #6. LVN Z said she assessed Resident #6, gave her some pain medication, took her to her room to assess her, and then brought her back to the dining room to eat dinner and everything was fine. LVN Z said she did not see any obvious signs of injuries and Resident #6's pain seemed to be managed. LVN Z said a STAT x-ray was ordered for Resident #6, she notified Resident #6's RP, the DON, ADON, and the doctor of the incident. LVN Z said during the assessment, there was not any discoloration or bruising to make her think something was injured but the resident did have a slight limp when she pivoted to sit in the chair. LVN Z said before the incident, Resident #6 was completely and independently ambulatory but the next day she was not able to walk so that nurse on shift sent her to the hospital. LVN Z said at the hospital, they found out she had a pelvic fracture. LVN Z said Resident #7 has not been physically aggressive towards other residents before, only combative during care with staff. LVN Z said Resident #7 does get upset though when people were talking around her, thinking that they were talking to her. LVN Z said she knew the Administrator was the abuse coordinator for the facility and that a resident-to-resident altercation that resulted in injuries would be considered abuse. LVN Z said she would report that situation to the Administrator but did not think it was abuse at the time so she did not immediately report the situation. LVN Z said because Resident #7 had dementia and was very confused she did not think it would be considered abuse at the time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 12:23 PM with CNA V revealed it was around dinner time while staff were serving trays, and Resident #7 was talking to the air and yelling and some residents were replying back to her. CNA V said they were trying to calm the residents down and telling them to relax. CNA V said all of a sudden, she saw Resident #7 get up and storms over to push Resident #6 down. CNA V said she went over to stay at Resident #6's side until LVN Z came over. CNA V said after LVN Z took over, she went to check on Resident #7 who was in her room upset but wanted to be left alone. CNA V said Resident #6 looked like she was injured after being pushed because she was shouting and screaming in pain. CNA V said before the incident occurred, Resident #6 was up and walking around and did not need a wheelchair or walker. CNA V said Resident #7 did not have any physically aggressive behaviors before this incident. CNA V said she knew to report abuse to the Administrator who was the abuse coordinator for the facility. CNA V said she was not sure why she did not report the situation to the Administrator. Interview on 02/27/25 at 2:36 PM with the DON revealed he received a report that Resident #6 had a fall and then the resident complained of pain and was sent to the ER. The DON said that another resident (Resident #7) had pushed Resident #6 and she fell . The DON said Resident #6 had a pelvic fracture. The DON said he was notified immediately after it happened and when Resident #6 was sent to the ER. The DON said Resident #7 was a little feisty with staff during care but has never attacked another resident. The DON said he was not sure what happened to make Resident #7 push Resident #6 but that it was an accident and was not intentional. The DON said he talked to Resident #7 and she did not mean to hurt anyone, but a resident-to-resident altercation was considered abuse. The DON said he would have to ask the Administrator if she reported the situation or not. The DON said all residents had the right to be free from abuse and all staff were responsible for making sure residents were free from abuse. The DON said Resident #6 was harmed from the situation because she suffered a pelvic fracture and now required the use of a wheelchair. The DON said Resident #6 was independently ambulatory before the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 02/27/25 at 3:03 PM with the Administrator revealed what she understood was that the situation happened in the hallway, LVN Z was standing there and talking with Resident #6 when Resident #7 walked past and bumped her, causing Resident #6 to fall and sustained a fracture. The Administrator said when she spoke to the staff about it, she did not get the impression that it was intentional. The Administrator said Resident #6 was able to ambulate independently before the incident and since the fracture occurred she now used a wheelchair. The Administrator said she did not complete an investigation into what happened because of what she was told by the staff. The Administrator said she only talked to LVN Z about the incident but was not aware that she did not see what had happened. The Administrator said she did not speak with CNA V who witnessed the incident between the two residents. The Administrator said she only knew that Resident #6 had a fall and an x-ray was ordered which had negative results but she was still complaining of pain. The Administrator said since she was still complaining of pain the facility sent her to the ER and that was when they found out about the fracture. The Administrator said if LVN Z documented that Resident #7 pushed Resident #6 then that was intentional and has a different connotation than an accidental bumping into each other. The Administrator said with the new information regarding the situation, it was considered abuse between two residents. The Administrator said she would have wanted staff to report the incident to her immediately. The Administrator said if she had known the details of the incident she would have reported it to HHSC. The Administrator said all residents have the right to be free from abuse, even from other residents. The Administrator said everyone was responsible for making sure that residents were free from abuse. The Administrator said the purpose of keeping residents safe from abuse was to ensure their continued health and safety. The Administrator said all staff were responsible for reporting abuse to her immediately. The Administrator said if staff were not immediately reporting abuse to her then that could pave the way for people to be injured or harmed in some way or for abuse to continue. The Administrator said she expected all staff to follow the facility's abuse policy. The Administrator said she would have completed an investigation into the situation had she known about the details beforehand. The Administrator said her investigation would have included resident records, witness statements, safe surveys, assessments, and education with staff. The Administrator said if there was not an investigation into what happened, there would not be measures in place to make sure residents were safe from abuse. The Administrator said if she did not know what happened she could not fix it. The Administrator said she and the DON would be responsible for completing the investigation together. Record review of the facility's Course Completion History report from 09/12/24 to 03/12/25 regarding Abuse, Neglect, and Exploitation Training reflected the following: LVN Z had completed the trainings on 11/30/24 and 02/2/25; CNA V had completed the training on 02/11/25. Record review of the facility's policy, revised September 2022, and titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating reflected: Policy statement: All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation; Reporting Allegations to the Administrator and Authorities, 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .Investigation Allegations: 1. All allegations are thoroughly investigated. The administrator initiates investigations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Birchwood of Grapevine		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Autumn Drive Grapevine, TX 76051	

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on interview and record review, the facility failed to ensure personnel provided basic life support, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 8 residents (Resident #11) reviewed for CPR. LVN A failed to initiate CPR when Resident #11 did not have a State recognized advance directive which meant the resident was a Full Code status, and he was found on the floor on the fall mat with his face noted to be reddish purple, weak pulse with no obvious respirations or breathing patterns noted. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could affect the residents by placing them at risk for a delay in intervention and life-saving treatments, which could result in death. Findings included: Record review of Resident #11's MDS dated [DATE] reflected the resident was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included stroke, heart failure, high blood pressure, diabetes, aphasia (language disorder), alcohol abuse, other psychoactive substance abuse, and cerebral ischemia (condition where the brain does not receive enough blood flow, leading to a lack of oxygen and nutrients). Resident #11's cognition was moderately impaired with a BIMS score of 11. The MDS further reflected the resident required assistance with most all ADLs. Record review of Resident #11's care plan revised on [DATE] reflected he was a full code. Interventions included to initiate basic life support CPR if the resident was without a heartbeat or not breathing. Record review of Resident #11's progress notes dated [DATE] documented by LVN A reflected the following: 8:45 PM (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Upon walking halls in observation of residents, this nurse, upon peeping into res room, noticed resident in prone position while on landing mat appearing asleep. Called res name while attempting to clear visual of res and/or breathing pattern while entering room. After reaching resident, head noted on pillow slightly tilted, face abnormal in color appearing reddish purple. Neck palpated. Weak pulse ascertained. Sternal rub to no avail. No obvious respirations or breathing pattern noted. Nurses X2 assisted res to bed as other nursing staff initiated Emergency response while simultaneously checking resident's code status. During this time at res bedside, O2 initiated and continued efforts were made to arouse res. by this nurse. Res, per demographics in echart, reported to be a DNR as relayed by additional staff. 9:00 PM Emergency response noted in facility in resident's room. Writer informed first responders of said code status as documented in echart. Cpr initiated by fire dept pending receipt of physical copy of advance directives with md signature. This nurse continued to obtain signed verification of code status while calling resident's [family] several times at both listed numbers to no avail. Resuscitation efforts continued awaiting requested info. Spoke with Resident #11's [friend] first contact to notify of incident. Speaker was aware of res code status but did not know specifics, he stated. [sic]Contnued to try to reach [family] in which after approximately 15 min did answer. Was informed by resident's [family] who is listed as surrogate per [county] stated in hospital dnr received upon admission [DATE] that is was resident's wishes to decline life saving measures in the event res codes or is incapacitated, he explained. Per fire dept, they were attempting to reach [family] in which I did notably transfer call to fireman to confirm res code status as explained. [Family] spoke with said fireman in which he stated twice that I was his father's request to not be resuscitated. Emergency did inform res [family] that they would be ceasing resuscitation in 15 min 9:15 PM .Cellphone was brought to this nurse by fire dept in which their medical director stated the requirements of dnr also informing me that the issue 'would be moved up' in chain due to our inability to produce said document During conversation with their medical director I, in fact had located hospital dnr signed by NP with surrogate [family] present and in aggreeance with resident's wishes to not perform 'life saving measures' decision was made by the fire dept to transfer res to ER also stating 'we would probably get a visit tomorrow morning' This nurse stated to fire dept [family] was awaiting on line in which he then informed to tell [family] they were transferring him to hospital after obtaining signs of life after resuscitation because we could not produce documentation Record review of Resident #1's monthly physician orders for February 2025 reflected LVN B input an DNR order on [DATE]. Further review of Resident #1's electronic health record reflected there was not a State recognized Advance Directive nor an Out-of-Hospital DNR for Resident #1. Record review of Resident #11's hospital form titled Medical Orders for Scope of Treatment dated [DATE] signed by a nurse practitioner reflected A Do Not Attempt Resuscitation/Allow Natural Death .D. Direct conversation with surrogate decision-maker/proxy for incapacitated patient (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Surrogate/Proxy Name: [Resident #1's family] Relationship: Adult Child Primary Contact Number: Designated in: Texas Statutory Surrogate Signature of Physician [NP] Date and Time: [DATE] 4:08 PM Record review of Resident #11's Fire Department Run Form dated [DATE] reflected the following: A Physician Resuscitation Order: Has no pulse or is not breathing. Do Not Attempt Resuscitation/Allow Natural Death Narrative: Subjective Medic was called for a reported breathing problem at 1500 [Facility] in the [City]. Call notes stated 'faintly breathing//currently getting oxygen', 'patient is confused' 'patient has dementia'. On arrival, a [AGE] year old male made was found in cardiac arrest. Staff stated the patient has a DNR. Staff later stated they could not find the DNR. Multiple attempts to contact patient's family were unsuccessful. Objective: At 20:57, the patient was lying supine on the bed. A NRB was on the patient's face, placed by staff, with oxygen connected but no staff was nearby. Initial assessment revealed the patient was pulseless and apneic (a condition where breathing temporarily ceases). The patient's skin was mottled by warm. The patient had no visible trauma or external bleeding. Assessment: The field impression of the patient was Cardiac Arrest Plan: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Upon finding the patient pulseless and apneic a 4-lead was established (a diagnostic tool that uses four electrodes to record the heart's electrical activity) and the patient was confirmed to be in asystole (a cardiac arrest that occurs when the heart stops beating and there is no electrical activity. After the staff stated that they could not find the DNR, the patient was transferred to the ground and CPR was initiated. Using the face sheet, family was contact was attempted but failed After 15 minutes of ACLS (Advanced Cardiac Life Support- a set of medical procedures and skills used to treat cardiac emergencies) the patient had a rhythm change for asystole to PEA (Pulse Electrical Activity - type of cardiac arrest where the heart's electrical activity is present, but there is no pulse) Due to the change in rhythm and rate of PEA, medical direction instructed us to transport the patient to the ER No further change in rhythm was noted throughout transport. Upon arrival at the ER the resident was transferred from the stretcher to the hospital bed The medical director checked heart motion and continued CPR for two more minutes before ending resuscitation attempts. Multiple attempts to contact LVN A on [DATE] and on [DATE] were unsuccessful. Attempts to contact Resident #11's family on [DATE] were unsuccessful. Interview on [DATE] at 1:21 PM with the Social Worker revealed Resident #11 was a full code and did not have DNR paperwork. The Social Worker said someone in the family said they had been discussing Resident #11 become a DNR but that was a far as that went, and nothing else was said . Interview on [DATE] at 4:24 PM with LVN C revealed LVN A said she was making rounds, [DATE], when she found Resident #11 unresponsive, and he had gone to assist and noticed he had a weak pulse. The resident's lips were blue, and he was not responding. LVN C said they checked the computer, and it showed the resident was a DNR and 911 was called. When EMS arrived, they asked for Resident #11's DNR paperwork and they were not able to produce it, so EMS started CPR as LVN A and LVN C continued to look for the DNR. LVN C said that because they thought Resident #11 was a DNR, the AED machine was not applied. LVN C further stated he heard one of the EMS staff members say Resident #11 had flatlined when they put the machines on the resident . Interview on [DATE] at 1:29 PM with the ADON revealed she was not aware CPR had not been initiated on Resident #11 on [DATE] and if the resident was a full code, then CPR should have been initiated . Interview on [DATE] at 2:07 PM with the DON revealed he was told Resident #11 had coded, [DATE], and had been found unresponsive. The DON said the resident just returned from the hospital, [DATE], and with a DNR but it was not an Out of Hospital DNR. Based on the progress notes, had read Resident #11 had a weak pulse, put oxygen on, and staff dialed 911. The DON said it appeared the AED was not used because the resident still had a pulse. The DON also said it appeared LVN A was unsure if Resident #11 was a full code. The DON further stated the staff could have used the AED machine to confirm the resident had a pulse . The DON further stated CPR should have been initiated if a resident was a full code or the code status was unknown. Interview on [DATE] at 5:47 PM with the Administrator revealed the EMS had met with her, because they had a concern, because the staff had gone back and forth whether Resident #11 was a DNR on [DATE]. The Administrator said it appeared they had a hospital DNR on file and the nurse, LVN A, did not know it was not valid in a nursing home. The EMS told her they required an Out of Hospital DNR and the facility staff should have started CPR when Resident #11 was found unresponsive . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 1:18 PM with the Physician revealed Resident #11 was known to the facility and the nurses assumed the resident was a DNR because the resident had a hospital DNR. He said he was glad the resident was not revived because everyone knew that is what Resident #11 wanted. The Physician said nursing homes required Out of Hospital DNR's and that paperwork should be done when the residents were admitted . He further stated if the residents were a full code, CPR should be initiated if they code. Interview on [DATE] at 9:08 AM with the EMS Captain revealed they were called to the facility for a resident having difficulty breathing. When EMS arrived, they found Resident #11 with oxygen on a high flow, and he was not breathing. When the EMS crew put the monitors on the resident, he was flatlined. The EMS staff asked the facility staff if Resident #11 was a full code or a DNR. They were told the resident was a DNR but 20 or 30 minutes later the facility staff were still trying look for the DNR paperwork. When the facility staff finally said they found the DNR it was make shift from a nurse practitioner that was not valid in the state of Texas for a nursing home. He said Texas required an Out of Hospital DNR in a nursing home, otherwise the residents were a full code. The EMS Captain stated they were not able to get a heart beat on the resident and he had to be transported because they were able to get a PEA . They were not able to get in touch with the family so there was no one that could tell them to stop CPR. The EMS Captain further stated, after the incident, he met with the Administrator because he had been concerned there was so much confusion on whether a resident was a DNR or a full code. Record review of the facility's policy titled Emergency Procedure-Cardiopulmonary Resuscitation revised on , d+[DATE] reflected the following: .6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a licensed staff member who is certified in CPR/BLS shall initiate CPR .7. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR An Immediate Jeopardy/Immediate Threat was identified on [DATE]. The Administrator and DON were notified of the Immediate Jeopardy on [DATE] at 4:36 PM. The IJ template was provided to the facility on [DATE] at 4:45 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The facility's Plan of Removal for the Immediate Jeopardy was accepted on [DATE] at 9:00 AM and reflected the following: Immediate Corrective Action for residents affected by the alleged deficient practice: On [DATE] the resident was noted to be in a prone position appearing asleep during staff rounds. The staff member entered the room and checked the resident who was noted with weak pulse but was unresponsive to sternal rub. At this time the facility called 911, while checking residents code status. The resident was placed on oxygen and efforts were made to arouse the resident who had a pulse. EMS arrived at the facility and began resuscitation efforts for the resident, who was taken to [Hospital] by the EMS team. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Actions taken to prevent a serious adverse outcome from recurring: This deficient practice had the potential to affect all residents who reside in the facility, the EMS Captain visited the facility on [DATE] to discuss the incident with the administrator. At this time the administrator completed a code status audit of all residents residing in the facility. All were found to have the appropriate documentation in the miscellaneous section of the chart listed as advanced directives or out of hospital DNRs. The administrator also had the social worker complete a chart audit to double-check that no code statuses were missed. On [DATE] the administrator reached out to the EMS captain to inform him of the results of the audit and thank him for the collaboration with the facility. The director of nursing started an education on Code Status and CPR on [DATE], education continues at present. The director of nursing and administrator were educated by vice president of clinical services on the topics of: Code Status, Out of Hospital DNRs, when to initiate CPR, and when to apply the AED. This education took place on [DATE]. New training initiated on [DATE] will include all nurses. They will be educated on identifying the appropriate code status including out of hospital DNR vs. Hospital DNR, when to initiate CPR, and how to use the AED correctly. The nursing staff checks all residents for orders and appropriate paperwork on code status upon admission/readmission to the facility. This is checked again by the nurse management team in the morning meeting, and the social worker in weekly audits. The administrator and social services director will continue to audit code statuses weekly. All results will be discussed monthly in QAPI. The Medical Director was notified of the deficiency (F678) on [DATE]. When Actions will be complete: The [Facility] will have completed education by [DATE], if any staff member working in the facility is unable to be educated, they will be removed from the schedule until training has been provided. The [facility] requests the removal of the immediate jeopardy on [DATE]. Monitoring of the facility's Plan of Removal included the following: Record review of the facility DNR audit dated [DATE] revealed all residents had the appropriate paperwork if they were a DNR. Record review of 12 current facility residents on [DATE] revealed they had the correct code status, physician order, and Out of Hospital DNR in their clinical file. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of in-services dated [DATE] reflected staff were educated on code status, Out of Hospital DNRs, when to initiate CPR, and when to apply the AED. They were also educated to check all residents' orders and appropriate paperwork on code status before they input the order. Interview on [DATE] from 9:53 am to 4:00 PM with staff from various shifts were the Administrator, DON, ADON, LVN A, LVN B, LVN C, LVN D, LVN E, RN F, LVN G, and LVN H. All staff stated they were educated on the following: - On code status - Full code/DNR - Identify the difference between a hospital and Out of Hospital DNR - When to initiate CPR - If code status is unclear, resident is a full code until further notice and CPR will be initiated. - How to apply and use the AED - Verify through orders and paperwork a resident's code status before it is put in the computer system. Interview on [DATE] at 2:28 PM with the Social Worker she was responsible for conducting weekly DNR audits to ensure each resident had the correct code status. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:45 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm because the facility was continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. 43791 Based on observation, interview, and record review, the facility failed to equip rooms to assure full visual privacy for each resident for 4 of 20 residents (Residents #1, #2, #3, and #4) reviewed for privacy curtains. The facility failed to ensure Residents #1, #2, #3, and #4 had full visual privacy. This failure could place residents at risk of exposure while care was being provided. Findings included: Observation on 02/27/25 from 10:00 AM-10:30 AM of the Memory Care Unit revealed Resident #1's room had a privacy curtain that would not extend around the bed due to damage of the track. Residents #2, #3, and #4 had no privacy curtain at all. Residents were not in their rooms, staff kept residents in the dining area for observation. Residents were unable to give interviews. Interview on 02/27/25 at 12:27 AM with the Housekeeping Supervisor revealed her Floor Tech was responsible for changing out privacy curtains when they were soiled or damaged. If the track was damaged, then maintenance would have to fix the track. She stated the reason the curtains were needed was to provide each resident with privacy and dignity. She stated the Floor Tech was on leave currently. Interview on 02/27/25 at 5:04 PM with the Director of Plant Operations revealed curtains were not usually placed on his maintenace requests. He states staff would usually just notify him verbally when a curtain needed attention. He stated he did not know of any curtains that currently needed attention. Record review of the facility's Resident Rights policy, dated February 2021, reflected: .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; .t. privacy and confidentiality .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43791 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents for 5 of 40 residents (Residents #3, #5, #8, #9, and #10) and one unit reviewed for a clean environment. 1. The facility failed to keep the Memory Care Unit was free of offensive odors. 2. The facility failed to ensure Residents #3, #5, #8, #9, and #10 rooms were kept in a sanitary and comfortable manner. This failure could place the residents at risk of exposure to infectious material and decreased feelings of self-worth. Findings included: Observation on 02/27/25 at 10:00 AM revealed upon entry to the Memory Care Unit there was a urine odor throughout the unit. Two housekeepers were cleaning rooms on the unit. Observation on 02/27/25 from 10:00 AM-10:30 AM Residents #3, #5, #8, #9, and #10 rooms had dead bugs, food particles, dirt, and debris at the head of the beds and between the bed and the wall. Observation on 02/27/25 at 10:30 AM a third housekeeper and the Housekeeping Supervisor joined the other two housekeepers in cleaning the unit. Interview on 02/27/25 at 12:00 PM with the Housekeeper revealed there were two housekeeprs assigned to the unit every day. He stated they were responsible for cleaning the high touch items like handrails, sweeping and mopping the floors of the resident's rooms, emptying the trash and cleaning the bathrooms. He stated they usually did not pull all the furniture and beds and clean behind them unless they have been told to deep clean a specific room. Interview on 02/27/25 at 12:27 PM with the Housekeeping Supervisor revealed there were two housekeepers assigned to the Memory Care Unit every day and they were responsible for cleaning each room and the common areas. Each housekeeper was also to do a deep clean in one room each day. A deep clean meant moving all furniture, beds, et cetera and cleaning under and behind them. She stated the residents deserved a clean room to prevent insect infestation and for their dignity. She stated she was responsible for following up on the housekeepers and which room they had deep cleaned that day, but she did not track them. Record review of the facility's Resident Rights policy, dated February 2021 reflected: .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence .

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 43791 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program so that the facility was free of pests and rodents for 5 of 40 residents (Residents #3, #5, #8, #9, and #10) reviewed for effective pest control. The facility failed to ensure Residents #3, #5, #8, #9, and #10 rooms were free of pests. These failures could place residents at risk of exposure to bugs and bug bites. Findings included: Observation on 02/27/25 from 10:00 AM-10:30 AM revealed Resident #5's bathroom had two live cockroaches. Residents # 3, #8, #9, and #10 had dead cockroaches and other bugs at the head of their beds between the bed and the wall. Record review of the facility's Pest Control log revealed cockroaches had been reported every month since May 2024. Pest control had treated for cockroaches every month. The last visit was on 02/20/25. Interview on 02/27/25 at 5:04 PM with the Director of Plant Operations revealed bugs in the facility was an on-going problem. He stated it was an older building with multiple means of entry for bugs. He stated their pest control company treated the whole facility and any rooms that were identified by staff or residents as having live bugs. The pest control company also sealed up any openings they discovered during their treatments. He stated the dead bugs seen in the resident rooms were most likely related to the treatment on 02/20/25. He stated the residents deserved to have a bug and rodent free facility for their overall health. He stated he did not know of a policy for pest control other than they were required to have a pest control program. Record review of the facility's Resident Rights policy, dated February 2021, reflected: .1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence .