STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675913	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pflugerville Care Center	521 S Heatherwilde Blvd Pflugerville, TX 78660

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38073 Based on observation, interview and record review the facility failed to receives adequate supervision to prevent accidents for 2 of 8 residents (Residents #1 and 2) reviewed for falls. The facility failed to ensure Residents #1 and #2's care plan interventions related to falls and a fall risk assessment tool were implemented. Resident #1 fell on [DATE] and sustained a hip fracture requiring surgical intervention. This failure placed residents at risk of falls. Findings include: Review of Resident #1's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses including vascular dementia, muscle weakness, unsteadiness on feet, lack of coordination, abnormalities of gait and mobility, muscle wasting and atrophy (complete wasting away of part of the body), and need for assistance with personal care. Review of Resident #1's quarterly MDS assessment, dated 03/08/24, reflected a BIMS score of 05, indicating a severe cognitive impairment. It reflected she required substantial/maximal assistance with transfers and used a wheelchair. The section on falls reflected she had no falls since the prior assessment. Review of the care plan for Resident #1, dated 11/06/23, reflected the following: [Resident #1] has multiple risk factors for falls such as but not limited to: Dementia, history of falls, New environment, Unsteady gait and hypoglycemia (low blood sugar). HX of Fall in facility. [Resident #1] will be free from falls through next review. The following interventions were listed: Assess and assist resident to bathroom as indicated. Complete fall risk assessment upon admission, and PRN. Encourage resident to have wheelchair by bed side. Encourage/assist resident to utilize footwear with non-skid soles. (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure pathways are clutter free. Fall interventions such as call light in reach, encourage me to call for assistance. Fall mat placed at bedside. Keep resident closer to the nursing station. Medication review for high-risk meds and psychological referral. Monitor vital signs/neuro checks as indicated. Notify physician and responsible party if a fall occurs. Place bed in lowest position. Place personal belongings within reach. Provide adequate lighting. PT/OT eval and treat if indicated. Staff to have resident redirected to more supervised area when up in chair. Review of Fall Risk Assessments for Resident #1 reflected one was conducted on 11/06/24 and 03/29/24 with none completed in between. Both assessments noted Resident #1 had a high risk of falls. Review of incidents for Resident #1 reflected falls on 11/06/24 and 03/29/24. Review of the incident for Resident #1's fall on 03/29/24 reflected she fell after attempting to transfer herself from her chair to her bed without calling for assistance and sustained a femoral (hip) fracture. No falls after her re-admission on 04/03/24 were reflected. Review of nursing progress notes for Resident #1 reflected the following, documented by LVN D: 03/29/24 04:20 PM [Resident #1] was transferred to a Hospital on 03/29/2024 4:20 PM related to Falls send for Head Ct-scan. 03/29/24 04:53 PM CNA was passing and saw resident on the floor and resident fell out her wheelchair. CNA called the nurse and another CNA. Nurse went to see resident and saw resident on floor. Resident was asked did she hit her head and she stated yes. Resident hit her head and bruise was on the forehead. vitals signs done: B.P:128/60, Pulse:68, Resp:18, Tempr:97.4, Oxygen:97% RA. On call NP notified. DON/ADON aware. Resident RP self. 03/29/24 05:00 PM After CNA told resident was on floor and nurse went to room; assessed resident. resident was on floor with her stomach facing down near to bed and asked resident how she fell and resident was not able to answer how she fell ed. Resident state 'I don't know how I fell .' (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of hospital records for Resident #1 reflected the following dated 03/29/24 06:44 PM Left nondisplaced femoral subcapital fracture (fracture of the neck of the thigh bone). Pt. is 81y f presenting to the hospital after an unwitnessed fall at her nursing home. Pt is now s/p L femur perc pinning (surgical procedure in which steel pins are entered through the skin to set a bone. Review of nursing progress notes for Resident #1 reflected the following, documented by LVN D: 04/03/24 03:40 PM Resident readmitting to facility. She remains assigned room [ROOM NUMBER]A. Call to notify family of her arrival with no answer to phone. Unable to get weight noting fractures. Will continue to monitor. Review of the significant change MDS assessment for Resident #1, dated 04/15/24, reflected she was completely dependent with transfers and used a wheelchair. Review of an ad hoc QAPI meeting sign-in sheet dated 04/02/24 reflected the QAPI committee was present, and the unwitnessed fall with injury sustained by Resident #1 was the topic of the meeting. Review of a QAPI tool titled, Fall Unwitnessed/Unexplained by Resident with Injury Monitoring reflected the following quality monitoring tools were documented as completed by the DON from 04/02/24 through 04/18/24 with no findings of non-compliance with facility protocol and no additional findings: -10 nursing staff members per week how to locate fall prevention interventions. Document dates/times, the staff members name, if they responded correctly, and any corrective action if needed. -During incident/event review in stand-up, the Don and Admin will monitor for falls and will investigate each fall to ensure that interventions at the time of the fall were in place and determine if additional interventions are required. Care plan and initiate any intervention changes at that time. -The DON and/or ADON will review at least three times per week to ensure all fall interventions are in place. -At least five times per week the Don/designee will monitor any resident unwitnessed falls or hit their head during the fall to ensure neuros are complete and physician was notified of new negative changes in neuro status. -At least five times per week the DON/designee will interview any resident that has fallen in the last seven days to determine if they have unaddressed pain or uncontrolled pain. Enter yes or no for unaddressed/uncontrolled pain in the column. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/03/24 at 02:57 PM, CNA E stated she was the aide who discovered Resident #1 had fallen on 03/29/24. CNA E stated she had helped Resident #1 go to the toilet at about 03:50 PM and had helped her back into her wheelchair. CNA E stated she had offered to help Resident #1 get into bed and lay down, but Resident #1 wanted to stay in her wheelchair in her room. CNA E stated Resident #1 spent a lot of time in the area by the nurse's station because she got sad and liked to see the people, but she was not sad the day she fell . CNA E stated she gave Resident #1 the call button and reminded her to use, locked her wheelchair brakes, and continued rounds. CNA E stated Resident #1 did not really self-ambulate in her wheelchair. CNA E stated she heard Resident #1's roommate yelling half an hour, so CNA E ran to the room, and Resident #1 was laying on the floor face down in front of her wheelchair. CNA E stated she went to get the nurse at that time, and the nurse took over. CNA E stated she had been in-serviced on fall prevention after the incident occurred. During an interview on 04/03/24 at 03:05 PM, RN F stated she did the assessment after Resident #1 fell on [DATE], because it was a Friday afternoon, and she was the RN in the building. RN F stated Resident #1 said she hit her head and had a bump on her head, so they sent her out to the hospital. RN F stated they really had not had to worry about Resident #1 being impulsive lately and it was a surprise she stood up that day. RN F stated the interventions for Resident #1 were the usual interventions to prevent falls: therapy, low bed, fall mat, call light, non-slip footwear. RN F stated these interventions were all in place at the time of Resident #1's fall on 03/29/24. Observation on 04/03/24 at 04:25 PM revealed Resident #1 returned to the facility on a stretcher carried by EMS personnel. She had some facial bruising visible. She was greeted by several staff members and chatted with them as she was waiting for her bed to be ready to transfer into. She said hello and smiled but did not participate in an interview. Observation on 04/18/24 at 10:30 AM revealed Resident #1 asleep in her bed, one side of which was up against the wall and was set in the lowest position with a fall mat next to the other side. Her bedside table was next to her with a pitcher of fresh ice water and a television remote. The call button was clipped to her pillowcase and rested under her hands folded across her upper abdomen. Her room was tidy, well-lit, and her wheelchair was next to her bed with locked brakes. Observation on 04/18/24 at 11:37 AM revealed Resident #2 in the therapy gym at the facility with PT A. She was wearing purple non-skid socks, and PT A assisted her with standing. She had great difficulty and was completely dependent on PT A for assistance. She bore very little weight when she stood, which was only for two seconds. After she sat back down she said That was very hard, but it didn't hurt so much. PT A assisted her in her wheelchair (total assistance) to the common area in front of the nurse's station, where he placed her wheelchair next to another female resident who greeted her in a friendly way. The two residents chatted and looked out the window for the next hour. Resident #1 did not attempt to stand or bend down. The receptionist was seated at the desk within eyeline of Resident #1 the entire time. At 12:40 PM, the DON assisted Resident #1 to the dining room, where she spent the next hour eating lunch, drinking coffee, and talking with her tablemates. At 01:42 PM, CNA B moved Resident #1 in her wheelchair to her room, pulled back her bedsheets, and CNA B and C assisted Resident #1 into bed using a gait belt. CNA B asked Resident #1 to lean forward and applied the gait belt as CNA C locked her wheelchair brakes. CNA B asked if Resident #1 was ready, and Resident #1 said, You bet. CNA C explained they were going to count to three and help her stand up, and CNA B counted to three. They shifted her over to the bed, and she said, Thank you sir, you saved my rear end. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interviews on 04/18/24 between 02:00 PM and 02:30 PM, CNA B, CNA C, and LVN D each reported they had been recently in-serviced on fall prevention in general and specific fall prevention for Resident #1. During an interview on 04/18/24 at 02:32 PM, the NP stated she was the primary physician designee for Resident #1 and saw Resident #1 two-three times per week. The NP stated she did not think Resident #1's fall could have been prevented, because she was impulsive at times, did not always want to stay at the nurse's station, and the facility did not provide 1:1 supervision for her. The NP stated the facility was aware of recurrent falls and continued to attempt interventions for them, but unfortunately Resident #1 would sometimes get up for one reason or another. The NP stated Resident #1 could be redirected, but her short-term memory was not very good, and she would forget the redirection quickly. The NP stated it would not be realistic for every resident with these characteristics to have one-to-one supervision all the time, so they did the best they could with reminders and frequent checks. Observations on 04/18/24 at 02:10 PM and 02:49 PM revealed Resident #1 laying in her bed, which was in low position, fall mat next to the bed, and call button in her hand. She was asleep, and her wheelchair was next to her bed with the brakes locked. Her room was tidy, and well-lit. Review of Resident #2's undated face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses including hemiplegia and hemiparesis following cerebral infarction (paralysis on one side of the body from a stroke), lack of coordination, muscle wasting and atrophy (complete wasting away of part of the body) and need for assistance with personal care. Review of Resident #2's quarterly MDS assessment, dated 03/02/24, reflected he was independent with transfers and used a wheelchair. The section on falls reflected he had no falls since the prior assessment. Review on 04/03/24 of the care plan for Resident #2, dated 11/06/23, reflected the following: [Resident #2] has multiple risk factors for falls such as: hemiparesis/hemiplegia left nondominant side. Risks for injury from falls will be minimized through next review. Complete fall risk assessment upon admission, quarterly and PRN. Review of Fall Risk Assessments for Resident #2 reflected one was conducted on 10/20/23 and none completed since. The assessment noted a low risk of falls. Review of incidents for Resident #2 reflected a fall on 10/20/23. During interview and observation on 04/03/24 at 04:29 PM, Resident #2 stated he had not fallen in the facility, that he remembered. He was seated in a wheelchair next to his bed, was clean and groomed, and his environment was free of hazards. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 04/03/24 at 03:54 PM, the DON stated she was the person primarily responsible for ensuring care plan interventions were implemented. She stated most interventions went on the CNA documentation system or the TAR so they would be completed each day. The DON stated the fall risk assessments were completed by the charge nurses when the system triggered it was time for them to be completed. She stated the system triggered the fall risk assessments triggered quarterly and the charge nurses working on the day they triggered were responsible for completing them. The DON stated she did not know why they had not been completed for Residents #1 and #2 since their last falls, but they should have been done. She stated she trained nurses to complete required assessments as soon as they started their shifts. She stated she monitored for compliance with the system by pulling reports and going over them in morning meetings. The DON stated she needed to investigate further and stepped out for a few minutes. When she returned, she stated the new company, which had bought the facility in June 2023, did not have the quarterly fall risk assessments triggered to send an alert on the EMR they set up for the facility but only required annual and PRN, when there was a fall. She stated they had identified an issue and would have to audit the whole facility to make sure there were no other examples of this. The DON stated fall risk assessments were important because patient assessments were how they knew the patients' needs. Review of in-services from January 2024 to April 2024 reflected an in-service on Fall Prevention conducted 04/02/24 and signed by the nursing staff. Review of the facility's policy, dated 10/05/16, titled Preventative Strategies to Reduce Fall Risk reflected the following: Policy: The goal of fall prevention strategies is to design interventions that minimize fall risk by eliminating or managing contributing factors while maintaining or improving the resident's mobility. After risk is assessed, individualized nursing care plans will be implemented to prevent falls.