

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675913	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2024
NAME OF PROVIDER OR SUPPLIER Pflugerville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of three residents reviewed for quality of care.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Ensure Resident #1 was transferred per her transfer status (hoyer lift with two-person assistance) on two occasions on [DATE]. On the first occasion, LVN A and CNA B lost their grip and Resident #1 slid to the ground. LVN A, CNA B, and CNA C transferred her from the ground to the bed without a hoyer lift. Approximately 24 hours later her legs were swollen, red, and warm to touch. She was transferred to the ER where she was diagnosed with two femur fractures. During surgery to repair the fractures, she had an embolism and subsequently passed away. - Ensure LVN A completed a fall assessment or documented the incident after Resident #1 slid to the ground during an inappropriate transfer. <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This deficient practice could place residents at risk for falls, injuries, hospitalization, and death.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of age-related osteoporosis (a condition that weakens the bones and increases the risk for fractures).</p> <p>Review of Resident #1's admission MDS assessment, dated [DATE], reflected a BIMS score of 13, indicating she had no cognitive impairment. Section GG (Functional Abilities and Goals) reflected assistance with sitting to standing and chair/bed-to-chair transfers were not attempted due to medical condition or safety concerns.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's admission care plan, dated [DATE], reflected she was at risk for falls with an intervention of utilizing a mechanical lift with staff x2 to assist with transfers. It further reflected she had an ADL self-care performance deficit with an intervention of requiring a lift for all transfers.</p> <p>Review of Resident #1's physician progress notes, dated [DATE], reflected the following:</p> <p>. [Resident #1] moves all 4 extremities without issues. She uses her wheelchair to propel around the facility.</p> <p>Review of Resident #1's progress notes, dated [DATE] at 9:15 PM and documented by LVN D, reflected the following:</p> <p>[Resident #1] observed going right back to sleep after waking up. O2 sat 81% on room air. HR 100. Left knee swollen and warm to touch .</p> <p>Review of Resident #1's progress notes, dated [DATE] at 10:42 PM and documented by LVN D, reflected the following:</p> <p>Send [Resident #1] to ER for eval and TX.</p> <p>Review of Resident #1's Transfer Form, dated [DATE], reflected the reasons for transfer to the hospital were AMS and lethargy.</p> <p>Review of Resident #1's hospital documentation, dated [DATE], reflected the following:</p> <p>Admission Diagnosis: Sepsis secondary to UTI</p> <p>Discharge Diagnosis: Suspected fat vs pulmonary embolism, Bilateral distal femoral fractures</p> <p>date of death : [DATE]</p> <p>Time of death: 3:28 PM</p> <p>Hospital course: [Resident #1] was initially treated for sepsis due to presumptive UTI based on urinalysis and CT abdomen report . because [Resident #1] complained of pain on both legs, an x-ray was done which revealed bilateral distal femoral fractures. [Resident #1] unfortunately was unable to provide accurate account of how she sustained these injuries. She said she fell but can't tell how or when.</p> <p>[Resident #1] was taken to the operating room earlier today for IM nailing of bilateral femur fractures. Following the IM nailing of left femur fracture [Resident #1] developed sudden onset of hypotension and briefly lost pulse . Altogether she had close to a dozen of these episodes of slowly worsening hypotension, followed by PEA, re-initiation of CPR resulting in ROSC and hypertension . resuscitative efforts were aborted after close to 3 hours of off and on CPR.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on [DATE] at 12:30 PM, LVN A stated she worked with Resident #1 on [DATE]. She stated around 9:30 PM, Resident #1 was sitting on the edge of the bed with her legs hanging off. She stated she kept saying she wanted to go to the kitchen and was very insistent. She stated she got CNA B and they each grabbed her for either side. She stated they lost grip of her, and she slid to the floor. She stated she did not realize she was a hooyer transfer. She stated she got CNA C to bring in a hooyer lift and they utilized the lift to transfer her. She stated the resident seemed stable and that was why she had not done an incident report. She stated she knew now she should have reported it and completed an incident report. She stated she waited until [DATE] to notify the facility of the incident because after being interviewed by the BON and police department, she realized she needed to give them all the details.</p> <p>During a telephone interview on [DATE] at 11:00 AM, CNA B stated she worked with Resident #1 on [DATE]. She stated it was close to end of her shift (10:00 PM) and she was doing her last rounds. She stated she heard LVN A call for help and found her in Resident #1's room. She stated Resident #1 was sitting at the end of the bed and was wanting to go to the dining room. She stated Resident #1 kept trying to get up. She stated she told LVN A they could not get her up because they did not know her transfer status as she was new to the facility. She stated LVN A stated, Well, let us just get her up. She stated she kept telling her they should not. She stated they ended up getting on either side of her and attempted to lift her, but she was too heavy, and she slid to the floor with LVN A behind her. She stated she went and got CNA C and the three of them transferred Resident #1 from the floor to her bed without a hooyer lift. She stated she was not aware she had been a hooyer transfer. She stated at the time, she did not think it had been considered a fall but had recently learned differently. She stated if she had seen the resident on the floor without a nurse present, she would have gotten a nurse immediately. She stated because LVN A had been there, she thought she was going to report it and document it.</p> <p>During a telephone interview on [DATE] at 10:30 AM, CNA C stated she worked with Resident #1 in July of 2024. She stated in the evening of [DATE] she was called to Resident #1's room by CNA B and saw Resident #1 on the floor with one leg crossed over the other and LVN A sitting behind her. She stated they did not use a hooyer lift to get her off the floor because it was difficult to utilize a hooyer when someone was on the floor. She stated LVN A held one side of her while CNA B held the other side of her, and she lifted her legs. She stated she did not see LVN A assess her after getting her into bed. She stated she did not seem to be in pain at that moment. She stated the next day, [DATE], Resident #1 was a completely different person. She stated she was not responding, was staring at the ceiling, and was grimacing as if she was in a lot of pain. She stated when Resident #1's FM got there later that day ([DATE]) she told her to make sure they sent her to the hospital because she did not look good. She stated she would have expected the nurse to treat the incident as a fall because she was on the floor. She stated the nurse she should have assessed her and documented the incident.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:23 AM, the NP stated he had not been working at the facility in July (2024) and did not know Resident #1. He stated if a resident slid to the floor, it would be considered a fall and he would expect a nurse to do a full assessment (including ROM), notify the NP/MD to let them know what was going on, and conduct neurological checks to ensure there was no change in condition. He stated if a resident was on the ground and required a hoier transfer, it may be okay to utilize staff (if there were enough) because some hoier lifts did not go all the way to the ground. He stated a possible injury that could occur if a resident slid to the ground could be an internal hematoma and they could for sure break their femur in that situation. He stated the elderly were very fragile and it was important to assess, follow-up, watch for changes in condition or pain. He stated that was why the on-coming nurse should be notified of any incidents and it must be documented. He stated documentation was extremely important because if you did not document it, whatever was going on with a resident could be missed. He stated an embolism could result from a femur fracture as it was a big bone. He stated it could happen within 24 hours or a few weeks.</p> <p>During an interview on [DATE] at 11:47 AM, the SC stated she was not notified of any fall in July of 2024 for Resident #1. She stated she believed it happened on the weekend and she did not work weekends. She stated if she had been notified about it, she would have notified the DON/ADON. She stated she was not told about the incident until that month ([DATE]) when a nurse (LVN A) was fired because of it. She stated a resident sliding to the ground would be considered a fall. She stated after LVN A was fired, all nursing staff were in-serviced on falls and the importance of documentation.</p> <p>During an interview on [DATE] at 12:55 PM, the ADON stated she was the one who conducted the in-services to all nursing staff after they were made aware of the incident that happened with Resident #1 (on [DATE]) on [DATE]. She stated in-services were conducted on abuse and neglect, fall prevention, a fall is a fall - whether a resident slid to the floor, incident reports, and documentation. She stated she also in-serviced on saying what you see and to never be a false witness for an incident. She stated all nursing staff should know a resident's transfer status before transferring a resident. She stated the aides were able to see transfer statuses in the POC and nurses could see transfer statuses in the residents' care plan. She stated documentation was very important; if you did not document, it did not happen. She stated nurses should document anything going on with a resident including incidents or a change in condition.</p> <p>During an interview on [DATE] at 2:54 PM, the DON stated her expectations on resident transfers were that they were safe, utilized the amount of assistance the resident needed, utilized gait belts, and hoier transfers were with two staff members. She stated aides could find a residents' transfer status in their POC system and the nurses found the status in the residents' care plans. She stated not following a resident's transfer status could result in injury. She stated if a resident slid to the floor during a transfer, which would be considered a fall. She stated her expectations after a resident fall were that the nurse completed an assessment, vitals, notify the NP, document, and complete and incident report. She stated documentation was important to ensure everyone was on the same page. She stated LVN A and all staff they interviewed after Resident #1 sustained the fractures denied ever seeing her on the floor or providing an inappropriate transfer. She stated they were not aware of the incident until LVN A came and reported it to them on [DATE]. She stated LVN A, CNA B, and CNA C were all terminated at that time.</p> <p>Review of the facility's undated Hydraulic Lift Policy reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance.</p> <p>Review of the facility's Preventative Strategies to Reduce Fall Risk Policy, revised [DATE], reflected the following:</p> <p>. 5. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s).</p> <p>Review of the facility's Documentation Policy, dated 2003, reflected the following:</p> <p>Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports and summary sheets (daily, weekly, monthly, discharge).</p> <p>.</p> <p>8. Documentation during and following an acute episode, following an event, and during physiologic, mental, or emotional changes or instability.</p> <p>Review of the facility's Abuse and Neglect Policy, revised [DATE], reflected the following:</p> <p>Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p> <p>The ADM and DON were notified on [DATE] at 3:15 PM that a past non-compliance IJ situation had been identified due to the above failures.</p> <p>It was determined these failures placed Residents #1 in an IJ situation on [DATE].</p> <p>The facility implemented the following interventions:</p> <p>During an interview on [DATE] at 11:38 AM, CNA H stated she had been recently in-serviced on transfer statuses, falls, and reporting what you saw. She stated she could find a residents' transfer status in the POC. She stated a hoier lift transfer required two people and you should never transfer a resident before checking their transfer status. She stated anytime a resident was on the ground, it would be considered a fall. She stated she would get a nurse immediately and would not move the resident herself.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:59 PM, LVN I stated she had recently been in-serviced on abuse and neglect, transfers, reporting, documentation, and classification of falls. She stated any change of plane such as sliding to the floor was considered a fall. She stated if a resident was found on the floor, she would assess for injuries, attempt ROM, complete an assessment, and document in the progress notes. She stated documentation was important so everyone knew what was going on with the resident and could watch for adverse effects. She stated she would notify the NP and DON immediately.</p> <p>Observation on [DATE] at 1:10 PM revealed the ADON demonstrating how the hooyer lift could descend low enough to lift a resident off the ground.</p> <p>During an interview on [DATE] at 1:33 PM, MA E stated when she worked with Resident #1 in July (2024) she never complained of pain. She stated she was recently in-serviced on falls, transfers, using gait belts, documentation, and hooyer transfers. She stated she would look in the POC to see a resident's transfer status. She stated if a resident slid to the ground during a transfer, it would be considered a fall. She stated if she found a resident on the ground, she would stay with the resident and call for help. She stated she would not move the resident or sit them up and would keep them calm until a nurse got there to assess them. She stated the Abuse and Neglect Coordinator was their Administrator and different types of abuse included financial, verbal, emotional, and physical.</p> <p>During an interview on [DATE] at 1:45 PM, LVN G stated their Abuse and Neglect Coordinator was their Administrator and different types of abuse included physical, verbal, and emotional. She stated she was recently in-serviced on changes in position (resident going from a higher to a lower level) and that it would be considered a fall. She stated when there was a fall she would assess the resident, take vitals, ask questions, and observe for blood or injury. She stated if there were visible injuries, she would send them out to be evaluated. She stated she would also complete an incident report, fall assessment, skin assessment, and document in the progress notes. She stated she would notify the NP and DON immediately. She stated when a resident was admitted they were evaluated by therapy for their transfer status, or their family would let them know. She stated she would find a resident's transfer status in their EMR. She stated she was also in-serviced on being truthful and documenting what she saw. She stated if a resident falls, she would call it a fall, and follow through with what she needed to do next.</p> <p>During an interview on [DATE] at 1:57 PM, CNA G stated the Administrator was the Abuse and Neglect Coordinator and types of abuse included verbal, physical, and mental. He stated he would never transfer a resident without knowing their transfer status which could be located in their POC. He stated if a resident was on the ground for whatever reason, it was considered a fall. He stated he would not move the resident until a nurse assessed them because something could be broken, and they needed to be assessed. He stated he was also in-serviced on being truthful about what you saw/heard regarding residents. He stated there always needed to be two people when providing a hooyer transfer.</p> <p>Review of Employee Disciplinary Reports for LVN A, CNA B, and CNA C, dated [DATE], reflected they had been terminated.</p> <p>Review of an in-service entitled Falls and Fall Documentation, dated [DATE], reflected all nursing staff were in-serviced on the following:</p> <p>MD/NP, DON/ADON and/or Nurse Manager MUST be notified.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>ANY change of plane is a fall.</p> <p>Fall meaning: A fall is an unintentional change in position from a higher to a lower level, such as a resident falling out of bed or from a chair.</p> <p>Skin observation and ROM assessment must be completed and all should be documented accordingly.</p> <p>Immediate actions after a fall: check for injuries, call for help, support and comfort resident, post-fall assessment and interventions, document the fall, review fall risk factors, implement fall prevention strategies.</p> <p>Review of an in-service, dated [DATE], reflected all nursing staff were in-serviced on locating transfer statuses for residents.</p> <p>Review of an in-service entitled Hoyer Transfer, dated [DATE], reflected all nursing staff were in-serviced on their Total Mechanical Lift Competency Checklist.</p> <p>Review of an in-service, dated [DATE], reflected all nursing staff were in-serviced on their Abuse and Neglect Policy.</p> <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42949</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for one (Resident #1) of three residents reviewed for accidents and hazards.</p> <p>The facility failed to:</p> <ul style="list-style-type: none"> - Ensure Resident #1 was transferred per her transfer status (hoyer lift with two-person assistance) on two occasions on [DATE]. On the first occasion, LVN A and CNA B lost their grip and Resident #1 slid to the ground. LVN A, CNA B, and CNA C transferred her from the ground to the bed without a hoyer lift. Approximately 24 hours later her legs were swollen, red, and warm to touch. She was transferred to the ER where she was diagnosed with two femur fractures. During surgery to repair the fractures, she had an embolism and subsequently passed away. - Ensure LVN A completed a fall assessment or documented the incident after Resident #1 slid to the ground during an inappropriate transfer. <p>The noncompliance was identified as PNC. The IJ began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before the survey began.</p> <p>This deficient practice could place residents at risk for falls, injuries, hospitalization , and death.</p> <p>Findings included:</p> <p>Review of Resident #1's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of age-related osteoporosis (a condition that weakens the bones and increases the risk for fractures).</p> <p>Review of Resident #1's admission MDS assessment, dated [DATE], reflected a BIMS score of 13, indicating she had no cognitive impairment. Section GG (Functional Abilities and Goals) reflected assistance with sitting to standing and chair/bed-to-chair transfers were not attempted due to medical condition or safety concerns.</p> <p>Review of Resident #1's admission care plan, dated [DATE], reflected she was at risk for falls with an intervention of utilizing a mechanical lift with staff x2 to assist with transfers. It further reflected she had an ADL self-care performance deficit with an intervention of requiring a lift for all transfers.</p> <p>Review of Resident #1's physician progress notes, dated [DATE], reflected the following:</p> <p>. [Resident #1] moves all 4 extremities without issues. She uses her wheelchair to propel around the facility.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of Resident #1's progress notes, dated [DATE] at 9:15 PM and documented by LVN D, reflected the following:</p> <p>[Resident #1] observed going right back to sleep after waking up. O2 sat 81% on room air. HR 100. Left knee swollen and warm to touch .</p> <p>Review of Resident #1's progress notes, dated [DATE] at 10:42 PM and documented by LVN D, reflected the following:</p> <p>Send [Resident #1] to ER for eval and TX.</p> <p>Review of Resident #1's Transfer Form, dated [DATE], reflected the reasons for transfer to the hospital were AMS and lethargy.</p> <p>Review of Resident #1's hospital documentation, dated [DATE], reflected the following:</p> <p>Admission Diagnosis: Sepsis secondary to UTI</p> <p>Discharge Diagnosis: Suspected fat vs pulmonary embolism, Bilateral distal femoral fractures</p> <p>date of death : [DATE]</p> <p>Time of death: 3:28 PM</p> <p>Hospital course: [Resident #1] was initially treated for sepsis due to presumptive UTI based on urinalysis and CT abdomen report . because [Resident #1] complained of pain on both legs, an x-ray was done which revealed bilateral distal femoral fractures. [Resident #1] unfortunately was unable to provide accurate account of how she sustained these injuries. She said she fell but can't tell how or when.</p> <p>[Resident #1] was taken to the operating room earlier today for IM nailing of bilateral femur fractures. Following the IM nailing of left femur fracture [Resident #1] developed sudden onset of hypotension and briefly lost pulse . Altogether she had close to a dozen of these episodes of slowly worsening hypotension, followed by PEA, re-initiation of CPR resulting in ROSC and hypertension . resuscitative efforts were aborted after close to 3 hours of off and on CPR.</p> <p>During a telephone interview on [DATE] at 12:30 PM, LVN A stated she worked with Resident #1 on [DATE]. She stated around 9:30 PM, Resident #1 was sitting on the edge of the bed with her legs hanging off. She stated she kept saying she wanted to go to the kitchen and was very insistent. She stated she got CNA B and they each grabbed her for either side. She stated they lost grip of her, and she slid to the floor. She stated she did not realize she was a hooyer transfer. She stated she got CNA C to bring in a hooyer lift and they utilized the lift to transfer her. She stated the resident seemed stable and that was why she had not done an incident report. She stated she knew now she should have reported it and completed an incident report. She stated she waited until [DATE] to notify the facility of the incident because after being interviewed by the BON and police department, she realized she needed to give them all the details.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Pflugerville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 521 S Heatherwilde Blvd Pflugerville, TX 78660	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During a telephone interview on [DATE] at 11:00 AM, CNA B stated she worked with Resident #1 on [DATE]. She stated it was close to end of her shift (10:00 PM) and she was doing her last rounds. She stated she heard LVN A call for help and found her in Resident #1's room. She stated Resident #1 was sitting at the end of the bed and was wanting to go to the dining room. She stated Resident #1 kept trying to get up. She stated she told LVN A they could not get her up because they did not know her transfer status as she was new to the facility. She stated LVN A stated, Well, let us just get her up. She stated she kept telling her they should not. She stated they ended up getting on either side of her and attempted to lift her, but she was too heavy, and she slid to the floor with LVN A behind her. She stated she went and got CNA C and the three of them transferred Resident #1 from the floor to her bed without a hooyer lift. She stated she was not aware she had been a hooyer transfer. She stated at the time, she did not think it had been considered a fall but had recently learned differently. She stated if she had seen the resident on the floor without a nurse present, she would have gotten a nurse immediately. She stated because LVN A had been there, she thought she was going to report it and document it.</p> <p>During a telephone interview on [DATE] at 10:30 AM, CNA C stated she worked with Resident #1 in July of 2024. She stated in the evening of [DATE] she was called to Resident #1's room by CNA B and saw Resident #1 on the floor with one leg crossed over the other and LVN A sitting behind her. She stated they did not use a hooyer lift to get her off the floor because it was difficult to utilize a hooyer when someone was on the floor. She stated LVN A held one side of her while CNA B held the other side of her, and she lifted her legs. She stated she did not see LVN A assess her after getting her into bed. She stated she did not seem to be in pain at that moment. She stated the next day, [DATE], Resident #1 was a completely different person. She stated she was not responding, was staring at the ceiling, and was grimacing as if she was in a lot of pain. She stated when Resident #1's FM got there later that day ([DATE]) she told her to make sure they sent her to the hospital because she did not look good. She stated she would have expected the nurse to treat the incident as a fall because she was on the floor. She stated the nurse she should have assessed her and documented the incident.</p> <p>During an interview on [DATE] at 11:23 AM, the NP stated he had not been working at the facility in July (2024) and did not know Resident #1. He stated if a resident slid to the floor, it would be considered a fall and he would expect a nurse to do a full assessment (including ROM), notify the NP/MD to let them know what was going on, and conduct neurological checks to ensure there was no change in condition. He stated if a resident was on the ground and required a hooyer transfer, it may be okay to utilize staff (if there were enough) because some hooyer lifts did not go all the way to the ground. He stated a possible injury that could occur if a resident slid to the ground could be an internal hematoma and they could for sure break their femur in that situation. He stated the elderly were very fragile and it was important to assess, follow-up, watch for changes in condition or pain. He stated that was why the on-coming nurse should be notified of any incidents and it must be documented. He stated documentation was extremely important because if you did not document it, whatever was going on with a resident could be missed. He stated an embolism could result from a femur fracture as it was a big bone. He stated it could happen within 24 hours or a few weeks.</p> <p>During an interview on [DATE] at 11:47 AM, the SC stated she was not notified of any fall in July of 2024 for Resident #1. She stated she believed it happened on the weekend and she did not work weekends. She stated if she had been notified about it, she would have notified the DON/ADON. She stated she was not told about the incident until that month ([DATE]) when a nurse (LVN A) was fired because of it. She stated a resident sliding to the ground would be considered a fall. She stated after LVN A was fired, all nursing staff were in-serviced on falls and the importance of documentation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:55 PM, the ADON stated she was the one who conducted the in-services to all nursing staff after they were made aware of the incident that happened with Resident #1 (on [DATE]) on [DATE]. She stated in-services were conducted on abuse and neglect, fall prevention, a fall is a fall - whether a resident slid to the floor, incident reports, and documentation. She stated she also in-serviced on saying what you see and to never be a false witness for an incident. She stated all nursing staff should know a resident's transfer status before transferring a resident. She stated the aides were able to see transfer statuses in the POC and nurses could see transfer statuses in the residents' care plan. She stated documentation was very important; if you did not document, it did not happen. She stated nurses should document anything going on with a resident including incidents or a change in condition.</p> <p>During an interview on [DATE] at 2:54 PM, the DON stated her expectations on resident transfers were that they were safe, utilized the amount of assistance the resident needed, utilized gait belts, and hoier transfers were with two staff members. She stated aides could find a residents' transfer status in their POC system and the nurses found the status in the residents' care plans. She stated not following a resident's transfer status could result in injury. She stated if a resident slid to the floor during a transfer, which would be considered a fall. She stated her expectations after a resident fall were that the nurse completed an assessment, vitals, notify the NP, document, and complete and incident report. She stated documentation was important to ensure everyone was on the same page. She stated LVN A and all staff they interviewed after Resident #1 sustained the fractures denied ever seeing her on the floor or providing an inappropriate transfer. She stated they were not aware of the incident until LVN A came and reported it to them on [DATE]. She stated LVN A, CNA B, and CNA C were all terminated at that time.</p> <p>Review of the facility's undated Hydraulic Lift Policy reflected the following:</p> <p>The hydraulic lift is a mechanical device used to transfer a resident from and to the bed and chair. It is reserved for those who are paralyzed, obese, or too weak to transfer without complete assistance.</p> <p>Review of the facility's Preventative Strategies to Reduce Fall Risk Policy, revised [DATE], reflected the following:</p> <p>. 5. Incident Reporting: Reported falls will be thoroughly investigated to assess fall risk factors and contributing factors in order to provide a safe environment for the resident(s).</p> <p>Review of the facility's Documentation Policy, dated 2003, reflected the following:</p> <p>Documentation is the recording of all information, both objective and subjective, in the clinical record of an individual resident. It includes observations, investigations, and communications of the resident involving care and treatments. It has legal requirements regarding accuracy and completeness, legibility and timing. Special forms in the clinical record are utilized in nursing documentation, such as assessment, care plan, nursing progress notes, flow sheets, medication sheets, incident reports and summary sheets (daily, weekly, monthly, discharge).</p> <p>.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 1:45 PM, LVN G stated their Abuse and Neglect Coordinator was their Administrator and different types of abuse included physical, verbal, and emotional. She stated she was recently in-serviced on changes in position (resident going from a higher to a lower level) and that it would be considered a fall. She stated when there was a fall she would assess the resident, take vitals, ask questions, and observe for blood or injury. She stated if there were visible injuries, she would send them out to be evaluated. She stated she would also complete an incident report, fall assessment, skin assessment, and document in the progress notes. She stated she would notify the NP and DON immediately. She stated when a resident was admitted they were evaluated by therapy for their transfer status, or their family would let them know. She stated she would find a resident's transfer status in their EMR. She stated she was also in-serviced on being truthful and documenting what she saw. She stated if a resident falls, she would call it a fall, and follow through with what she needed to do next.</p> <p>During an interview on [DATE] at 1:57 PM, CNA G stated the Administrator was the Abuse and Neglect Coordinator and types of abuse included verbal, physical, and mental. He stated he would never transfer a resident without knowing their transfer status which could be located in their POC. He stated if a resident was on the ground for whatever reason, it was considered a fall. He stated he would not move the resident until a nurse assessed them because something could be broken, and they needed to be assessed. He stated he was also in-serviced on being truthful about what you saw/heard regarding residents. He stated there always needed to be two people when providing a hoyer transfer.</p> <p>Review of Employee Disciplinary Reports for LVN A, CNA B, and CNA C, dated [DATE], reflected they had been terminated.</p> <p>Review of an in-service entitled Falls and Fall Documentation, dated [DATE], reflected all nursing staff were in-serviced on the following:</p> <p>MD/NP, DON/ADON and/or Nurse Manager MUST be notified.</p> <p>ANY change of plane is a fall.</p> <p>Fall meaning: A fall is an unintentional change in position from a higher to a lower level, such as a resident falling out of bed or from a chair.</p> <p>Skin observation and ROM assessment must be completed and all should be documented accordingly.</p> <p>Immediate actions after a fall: check for injuries, call for help, support and comfort resident, post-fall assessment and interventions, document the fall, review fall risk factors, implement fall prevention strategies.</p> <p>Review of an in-service, dated [DATE], reflected all nursing staff were in-serviced on locating transfer statuses for residents.</p> <p>Review of an in-service entitled Hoyer Transfer, dated [DATE], reflected all nursing staff were in-serviced on their Total Mechanical Lift Competency Checklist.</p> <p>Review of an in-service, dated [DATE], reflected all nursing staff were in-serviced on their Abuse and Neglect Policy.</p> <p>(continued on next page)</p>		

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