STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675977	A. Building B. Wing	05/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Creek Nursing & Rehabilitation	3825 Village Creek Rd Fort Worth, TX 76119

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - 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** 44405 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 4 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure adequate supervision on 05/08/24 when Resident #1 sustained contusions and bruises to left side of face and left eye from an incident/accident. On 05/09/24, Resident #1 was diagnosed with a subdural hematoma ([SDH] occurs when a blood vessel in the space between the skull and the brain [the subdural space] is damaged) and admitted to the hospital. The facility failed to oversee the implementation of resident care policies. LVN A failed to initiate and document investigation of an incident/accident on 05/08/24, per the facility's policy and procedure Fall Management Program, when Resident #1 sustained an fall. These deficient practices of inadequate supervision placed residents at considerable risk of serious injury, harm, and/or impairment. Findings included: Record review of Resident #1's Admission Record reflected a 77 y.o. female, who admitted to the facility on [DATE] transferred from Skilled Nursing Home. Resident #1 admitted under hospice services with a primary diagnosis of Senile Degeneration of Brain, Not Elsewhere Classified. History of diagnoses included: Cerebral Infarction ([Ischemic stroke], occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it); Acute Metabolic Acidosis, CKD Stage 3, and T2DM. Record review of Resident #1's Admission MDS assessment, dated 04/30/24 still in progress, revealed Resident #1 had a BIMS score of 3 which suggested Resident #1 had severe cognitive impairment. Resident #1's functional status required set-up for meals, one-person moderate assistance with ADLs, and a wheelchair for mobility. Record review on 05/12/24 of Resident #1's Baseline Care Plan, date initiated 04/30/24 still in progress, reflected: Resident #1 has a behavioral problem r/t placing linen and then self onto the floor (Initiated by LVN B on 04/29/24; Revised by the MDS nurse on 05/01/24). (continued on next page)

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	.at increased risk for falls r/t impaired cognition, Alzheimer's, impaired mobility, impaired safety awareness, recent admission The intervention(s) included Anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; PT evaluate and treat as ordered or PRN. The long-term goal indicated . will be free of falls through the review date. (Initiated by the MDS nurse on 05/01/24). .had an actual fall 5/8/24 r/t impaired cognition, impaired safety awareness, gait imbalance. The intervention(s) included anticipate resident's needs .observe for resident attempting to slide out of wheelchair and redirect/reposition as indicated. The long-term goal indicated will resume usual activities without further incident through the review date. (Initiated by the MDS nurse on 05/12/24). Record review of Resident #1's active physician orders reflected: - Start date 04/30/24: Monitoring the resident for significant behaviors with anti-anxiety medication use. Numbers were assigned as a code to reflect behaviors. Notify Physician if a behavior increases or a new behavior is noted. - Order date 04/30/24 at 4:00 PM: Alprazolam (prescribed to manage panic and anxiety disorders) 0.50 mg tablet Q6H PRN for agitation/anxiety for 14 days. - Order date 05/02/24 at 9:34 AM: Alprazolam 0.25 mg tablet, two 0.25 mg tabs, three times a day [7AM, 1PM, 7PM] for agitation/anxiety. - Order date 05/08/24 at 10:20 AM: Apply TAO to abrasions on bilateral knees until healed, notify MD for any s/s of infection each Day shift for skin treatment. - Order date 05/09/24 at 5:59 PM: Monitor Bruises to Left side forehead, left eyelid, back of left hand, back of right hand, right elbow x (2), right upper arm, left elbow, left side of face near left ear, right thumb, and Scratches x (2) to right arm every shift. - Order date 05/09/24 at 11:15 PM: Transfer to hospital for evaluation of bruising, redness and swelling, per family request. Record review of Resident #1's May 2024 TAR revealed documentation that anti-anxiety medication administered three times a day as scheduled. Record review of Resident #1's progress notes indicated: - 05/07/24 at 2:52 PM: LVN A wrote, [Resident #1] has abrasion area near Right knee and red area near left knee. The CNA reported this to this writer [LVN A] this morning. The CNA say when doing ADL care to get resident up for bkft she saw these areas. - 05/07/24 at 9:09 PM: LVN B wrote, .[Resident #1] was medicated with PRN Xanax [Alprazolam] earlier this shift for combativeness and verbal aggression. Reports that resident was purposely leaning forward in wheelchair and sliding herself to the floor . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- LATE ENTRY (on 05/10/24 at 2:17 PM) dated 05/08/24 at 3:30 PM: LVN A wrote, The resident [Resident #1] slid out of the wheelchair in the TV room. She was assessed and did not have any injuries. Resident was assisted to wheelchair and assisted to bed. - 05/09/24 at 4:52 PM: The AMD wrote, [Resident #1] . mild to moderate left facial bruising. no recommendations were made at that time other than to continue the hospice care plan. - 05/09/24 at 5:05 PM: LVN A wrote, [Resident #1] has bruises noted to left forehead, left eye lid. back of left hand, back of rt hand, rt thumb. rt elbow x (2). rt upper arm. Left elbow. left side of face near ear. Scratches noted to rt arm x (2). Resident leans to the side while propelling herself in wheelchair, her head touches the rails, and she must be redirected. The residents is combative toward staff members during assist with repositioning in wheelchair. The resident tore blinds off windows. The resident's hands also bump against the walls while she propels herself. Family members aware of bruises and poor appetite. Husband visiting today. - 05/09/24 at 7:30 PM: LVN B wrote, [Resident #1] being visited by family, husband, sister, and brother-in-law . Said Nurse [LVN B] approached by brother-in-law, who had concerns of bruising and redness that resident had. Went to room to assess resident. Upon assessment large area of redness noted to left side of face, including the ear, slight swelling noted under left eye. Large area of bruising noted to back of left hand and some bruising noted to back of right hand. ROM performed on both of resident's hands with no difficulty noted. Resident lying in bed sleeping deeply. No s/s of pain or discomfort noted. No facial grimacing or guarding noted during assessment. Family request that resident be sent to ER for evaluation. Spoke with RP who states that she wanted resident to be sent to hospital for evaluation of bruising and swelling. Call placed to Hospice Nurse as notification, AMD and NFA made aware. Incontinence care provided by CNA's. [Resident #1] became alert and combative during this process. Call placed to 911 (non-emergency), ambulance dispatched. EMT's arrived, [Resident #1] transferred out without any difficulty. - LATE ENTRY (on 05/10/24 at 9:16 AM): LVN A wrote, Late Entry for 5/9/2024. This Writer [LVN A] talked with (RP) and notified her of the residents' bruises that were found on her when this writer [LVN A] came on duty for morning shift. also talked. to her about the residents' condition. - LATE ENTRY (on 05/10/24 at 9:33 AM): LVN A wrote, Late Entry for 5/9/2024. This writer [LVN A] called and talked with Hospice Nurse about the resident continue to be combative during ADL care. also talked about resident condition and resident sleeping more. [Hospice Nurse] notified this writer [LVN A] that she talked with [RP] about the resident sleeping more but she and RP decided not to change any of the residents' current medications. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Incident Report #747, dated 05/07/24 10:29 AM, completed by LVN A indicated the incident occurred in the Resident's Room. The nurse [LVN A] indicated Notified by CNA [unidentified] that when she was doing ADL care on [Resident #1] this morning to get her up for bkft she saw skin abrasion near the right knee and also small red area was seen near left knee. The injuries observed at the time of incident included a scrape and bruise to the front of the right and left knees. Predisposing Physiological Factors listed: Recent change in Medications/New; Confused; Incontinent; Gait Imbalance; and Impaired Memory. There were no witnesses listed. Agencies/People Notified indicated, Family Member 05/07/24 at 2:50 PM; NFA 05/07/24 at 2:51 PM; DON 05/07/24 at 2:51 PM; AMD 05/07/24 at 2:38 PM. The end of the incident report reflected notes (entered by DON) during review the following morning (05/08/24): IDT reviewed: Attempt to redirect/deescalate resident when doing unsafe behaviors such as hitting out, sliding out of wheelchair or bed. Record review of Incident Report #753, dated 05/08/24 3:30 AM, completed by LVN A indicated the incident occurred in the Resident's Room. LVN A described the incident, CNA notified this writer [LVN A] that the resident [Resident #1] slid off the wheelchair onto the floor. assessment done. No injuries seen at this time. Resident [Resident #1] did not hit her head. She was lying on the left side with her head in the air. Resident assisted off floor into wheelchair and was taken and put in her bed. Resident [Resident #1] combative with staff while assisting her off floor. LVN A described immediate action taken, Assisted resident off the floor and placed in wheelchair. Then assisted the resident to bed. There were No injuries observed at time of incident. LVN A indicated predisposing physiological factors included recent change in Medications/New; Incontinent; Gait Imbalance; Impaired Memory. LVN A indicated an unidentified Staff witnessed the incident on 05/08/24. The witness statement indicated, CNA [later identified as CNA C] witnessed the resident sliding herself to the floor out of her wheelchair. The incident report indicated the NFA, DON, and AMD were notified 05/08/24 at 3:30 PM. The end of the incident report reflected notes (entered by DON), IDT reviewed: Observe resident for times when she is trying to slide out of her wheelchair and help her to reposition to a safe position. The incident report was locked 05/13/24 after review. A record review of hospital medical records for admitted [DATE] reflected [Resident #1] arrived at the emergency department (ED) on 05/09/24 at 8:50 PM. The ED Chief Complaint indicated per EMS from [SNF] family called due to [Resident #1] covered in contusions, bruises, on left side of face, bilateral hands unknown cause, [Resident #1] has history of dementia, hospice did a full HTT assessment (05/08/24) at 3:30 PM did not see any injuries. A review of the ED provider History of Present Illness at 8:54 PM revealed [Resident #1] presents to the ED via EMS for multiple contusions throughout body. Family found her with bruising and called 911. It is unknown why has bruising throughout her body. Per EMS, it is believed [Resident #1] fell . [Resident #1] has hx of dementia and is nonverbal during H&P. Skin findings: Abrasion (healing, bilateral knees) and ecchymosis (A bruise, or contusion - skin discoloration from damaged, leaking blood vessels underneath skin) present. Comments: Contusion to left hand, forearm, and anterior aspect of left ear. Contusion of right forearm and elbow. Old appearing contusion to right lateral chest wall. Right scapula contusion. Left sided periorbital ecchymosis. Pressure ulcer to coccyx. Lab Results Urinalysis Complete with Microscopic (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Abnormal CT Head (Computed Tomography Scan of the Brain), without IV Contrast (test of choice for detecting acute hemorrhage in the brain). Abnormal #CRITICAL#. Final Radiology Impression: Per radiology, [Resident #1] has subdural hemorrhage with small shift. Final diagnoses [05/09/24 at 10:27 PM] Subarachnoid hemorrhage (bleeding in the space below one of the thin layers that cover and protect your brain. a medical emergency that requires immediate treatment. often caused by head trauma and/or a ruptured brain aneurysm.); Contusion of face; Multiple contusions; UTI with hematuria. A review of Daily Progress Note dated 05/10/24 at 8:18 AM revealed, [Resident #1] brought in due to multiple areas of bruising and imaging noting left scalp hematoma and acute on chronic left subdural hematoma likely secondary to ground level fall. Assessment and Plan: 1. Acute on chronic subdural hematoma with midline shift . 2. Bruising - possibly from multiple falls 3. Hypernatremia (common electrolyte problem - a high concentration of sodium in the blood) 4. Altered Mental Status with somnolence (a state of drowsiness or strong desire to fall asleep) 5. UTI During an interview on 05/12/24 at 3:06 PM, the DON stated on 05/09/24 she counseled LVN A during the morning about the failure to document and gave a written warning. The DON said that the AMD assessed and evaluated the discovered bruises on Resident #1 around 4:00 PM and he did not have any concerns about the discolorations. The DON said that LVN A did not create an incident report and that is why she was unaware that Resident #1 had an incident/accident on 05/08/24. The DON said that Resident #1 was sent to the hospital on 05/09/24 per the family request. The DON stated that LVN A was removed from the schedule for intensive training with DON and RNC on ANE, Fall Management, resident safety, assess, evaluation, change in condition, incident reports, and documentation with posttests. LVN A was required to satisfactorily complete all training and demonstrate understanding before scheduled for next shift. The DON stated that the facility conducted surveillance that included HTT skin assessments on all residents assigned to the secured unit for undocumented skin issues/concerns - no concerns found. The DON indicated chart audits were conducted to ensure skin assessments and care plans were updated with appropriate interventions were in place and implemented for all residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/13/24 at 4:11 PM, LVN B stated that she worked Monday - Friday 2P - 10P in the secured unit (Hall 300). LVN B said that she admitted Resident #1 on 04/29/24. LVN B said that Resident #1 had fading bruises, yellow/green hue on her abdomen. LVN B said on 05/08/24 she arrived to work late at 3:40 PM. LVN B said that she saw CNA C coming out from the secured unit and yelling, I need some help . this woman [Resident #1] is on the floor, I can't get her up . she heavy . I need some men . nobody will come back here [secured unit]. LVN B said that she clocked in and entered the secured unit. LVN B said that she conducted walking rounds alone because LVN A was not present in the secured unit to give report. LVN B said she observed Resident #1 lying in bed, cursing, and waving arms around wildly. LVN B said that she was sitting at the nurses' station (outside the secured unit) when approached by a family member on 05/09/24 around 7:00 PM. LVN B said that the family member was concerned about bruises. LVN B said that she walked with the family member back to the secured unit to visualize Resident #1. LVN B said that she was astonished when she saw Resident #1. LVN B said that she observed light to dark red discoloration to the left side of Resident #1 face and left eye. LVN B explained to the family member she did not know what happened. LVN B informed the DON. LVN B said that the family member called the RP and placed the call on speaker. LVN B said that the RP indicated she was informed about faded bruises when Resident #1 was admitted to the SNF, was unaware of the newly discovered bruises and agreed to send Resident #1 to the hospital. During an interview on 05/13/24 at 5:19 PM, LVN E said that she worked 2P - 10P shift. LVN E said that she relieved LVN A on 05/08/24. LVN E said that LVN A reported to follow up on Resident #1 discoloration on arms. LVN E said that she did not recall if LVN E reported if Resident #1 had a fall. LVN E said that Resident #1 was observed in bed during walking rounds. During an interview on 05/13/24 at 5:41 PM, CNA C stated she worked Monday - Friday 2P - 10P in the secured unit (Hall 300). CNA C stated on Wednesday, 05/08/24 around 3:00 PM watched Resident #1 slid from her wheelchair to the floor but she didn't hit her head and was laying on the side [left]. CNA C said she went to find the nurse and someone to help get [Resident #1] up from the floor. CNA C said that she and the DOM helped Resident #1 back to the wheelchair then to bed. CNA C said that the DOM left and returned with a fall mat to place next to Resident #1's bed. CNA C said that since the resident slid from the wheelchair, she did not think at the time it was considered a fall. CNA C could not recall if LVN A assessed Resident #1 before CNA C and the DOM assisted Resident #1 to the wheelchair and then to bed. During an interview on 05/13/24 at 5:55 PM, the DOM stated that he was approached by CNA C on 05/08/24. The DOM stated CNA C said that she needed help getting a resident [Resident #1] off the floor. The DOM said that he helped CNA C get Resident #1 off the floor next to her bed. The DOM said that he went to get a fall mat to place next to the bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/15/24 at 10:51 AM, LVN A said that she worked Monday - Friday, 6A - 2P in the secured unit (Hall 300). LVN A described Resident #1 as confused and combative, could self-propel in wheelchair. LVN A said that Resident #1 was normally in the TV room with other residents or sometimes in wheelchair in the hallway. LVN A said that Resident #1 had frequent falls from the wheelchair due to behaviors, sliding out of the wheelchair on purpose. LVN A said she was at the front nurses' station, outside the secured unit, because the computer stopped working. LVN A said on 05/08/24 (sometime after 2:00 PM), CNA C told her that she saw Resident #1 getting out of the wheelchair and had a change in plane in the TV room. LVN A said that a change in plane is an unintentional change in position coming to rest on the ground or floor. LVN A said that was why she did not complete an incident report on that day because she did not think that it was a fall because CNA C said that Resident #1 intentionally went to the floor and thought it was more of a behavior. LVN A said that she never observed Resident #1 lay out on the floor as a behavior. LVN A said that she did not assess Resident #1 before CNA C got Resident #1 off the floor. LVN A said that she may have seen some redness, but nothing serious like an injury. LVN A said that CNA D called her to Resident #1's room on 05/09/24 and pointed out the bruising on Resident #1's left side of her forehead, her eye, her hands, her arm. LVN A said that when she saw the bruises, she wrote progress notes and an incident report about Resident #1's fall on 05/08/24. LVN A said that she typically has paper notes and had a lot of things going on and never got around to document on 05/08/24. During an interview on 05/15/24 at 12:14 PM, CNA D said that she was the Staffing Coordinator, still had her nurse assistant certification, and often work as a CNA. CNA D said that she worked on 05/09/24 and Resident #1 was part of her assignment. CNA D said that when she approached Resident #1 in her bed to assist with ADLs and prepare to eat breakfast, she noted the discoloration to the left temple and left eye. CNA D described the discoloration as a mid to dark red. CNA D said she immediately notified the nurse [LVN A]. CNA D said that LVN A did a head-to-toe skin assessment and CNA D saw discolorations to the arms and hands. CNA D said that she recalled being told in report on a day shortly after Resident #1 admitted that Resident #1 slid from the wheelchair to the floor on her bottom without injury or harm. CNA D said that whenever she worked with Resident #1, it was not known or ever observed Resident #1 use self-injurious behavior or falling to the floor on purpose. During an interview and records review on 05/15/24 at 12:34 PM, the NFA stated that when first learned of incident/accident on 05/09/24, she reported the incident to state agency for Injury of Unknown Origin and Resident Neglect and notified the police. A record review revealed a facility incident report submitted to state agency and a police report dated 05/09/2024. The NFA stated that she started an internal investigation. The NFA said that an incident report was required when a resident had a fall/near-fall, witnessed or unwitnessed, to prevent or minimize similar incidents. It was also an important step for correcting whatever led to the incident. The NFA stated that nurse documentation was imperative for continuity of care. Record review of a QAPI Plan dated 05/09/24 revealed guidance on the nurse responsibility following accident/incident(s) and related policy and procedure. The QAPI Plan outlined the Action, Responsible Person, Goal/Measure of success, and Evaluation date/result(s) elements. The Actions identified areas for improvement that included disciplinary action and one-to-one education with [LVN A], all-nursing in-service/training, and daily reports from nursing staff to identify risk of and to prevent undocumented incidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility's policy Falls - Evaluation and Prevention, revised June 2020, reflected the policy statement: It is the policy of this home to evaluate residents for their fall risk and develop interventions for prevention. Definitions of a fall, near fall, and un-witnessed fall were listed. The procedure reflected Upon Admission, the nursing staff/interdisciplinary care team should determine if a resident is at risk for falls and develop appropriate interventions based on the evaluation. The goal is to prevent falls if possible and avoid any injury related to falls . The steps that must be taken following a fall reflected: Evaluate the resident promptly in order to identify and treat injuries. The resident should not be moved until the licensed nurse has evaluated their condition . Following the resident's evaluation, transfer the resident to the appropriate surface and evaluate further if indicated . Complete the Accident/Incident report and notify the physician and responsible party . Review the plan of care and update the interventions as appropriate. Record review of the facility's policy Incident Investigation, revised August 2020, reflected: Policy Purpose: To ensure the Facility tracks incidents that take place at the Facility in an effort to increase the quality of care provided to residents. The policy indicated: The Facility will have a Licensed Nurse fill out the Incident/Accident Report as soon as possible. An incident included falls, unusual occurrence(s), and bruises. The steps of procedure in the event of an incident, the Licensed Nurse or the individual who first encountered or witnessed an incident would complete the Incident/Accident Report. Interviews with staff members and other witnesses would be documented. The DON and/or designee would review the information Incident Log monthly and compile a total of all reported incidents that month and submit to the QAPI Committee for review.