STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675989	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brazos Valley Care Home	605 S Ave F Knox City, TX 79529

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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	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49154 Based on interview and record review, the facility failed to ensure a resident had the right to be free from abuse, neglect, misappropriation of property, and exploitation for 1 of 8 residents (Resident #1) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #1's Synthroid/Levothyroxine (thyroid medication), when LVN B took the medication out LVN C's medication cart for her own personal use between 4/21/2024 through 4/28/2024 and/or 5/2/2024. This incident was witnessed by LVN C. This failure could place residents at an increased risk for not receiving their prescribed medication as ordered. Findings included: Record review of Resident #1's undated face sheet reflected Resident #1 was a [AGE] year-old male whose latest readmission to the facility on was 6/11/24, a current readmitted [DATE], as well as a discharge date of [DATE]. Resident #1 was his own resident representative with the following diagnoses: acute on chronic diastolic (congestive) heart failure (heart condition), Type 2 diabetes mellitus without complications (when the body does not use insulin properly), other specified hypothyroidism (underactive thyroid), schizoaffective disorder (mental health condition), and unspecified kidney failure (when your kidneys suddenly become unable to filter waste products from your blood). Record review of Resident #1's clinical record reflected his annual MDS assessment was completed on 6/28/2023 listing him with a BIMS score of 09, which indicated he was moderately cognitively impaired. Record review of Resident #1's medication administration record dated 4/1/2021 to 4/30/24 revealed an order for Levothyroxine tablet: 25 mcg; 1 tab once, a day, for a diagnosis of other specified hypothyroidism, for management of thyroid problems, with a start date of 12/06/23, and an end date of open ended. Record review of Resident #1's medication administration record dated 5/1/2021 to 5/31/24 revealed an order for Levothyroxine tablet: 25 mcg; 1 tab, once a day, for a diagnosis of other specified hypothyroidism, for management of thyroid problems, with a start date of 12/06/23, and an end date of open ended. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of letter signed by LVN C on 6/19/24 titled LVN C Interviewed revealed: On June 29, 2024, at approximately 1 :45 p.m., I interviewed LVN C about any information she may have concerning the allegations the facility had received about LVN B. LVN C reported there had been a day when she had left her med cart to get some supplies. When she returned, LVN B was in her cart. LVN B told LVN C that she needed some of Resident #1's Levo. LVN B was short of her own medication for a medical condition. LVN C said she does not give that med, other nurses do, but LVN B had a pill her hand and told LVN C she had taken some. Record review of letter signed by ADM D on 6/20/24 titled LVN B Interview revealed: I interviewed LVN B on June 20, 2024. In response to the allegations contained in the letter that LVN B received from the Board of Nursing, she reported the following: 3. I asked her about the allegation that she had taken one of Resident #1's Levothyroxine for her own personal use. She replied that she takes Levo and her prescription calls for her to take 175 Mg. The meds she has at her home are only 150 MG, they're 25 Mg short of what she needs. She said that she did go to the med cart and take one of Resident #1's out of the cart because his are 25 Mg and would make up the difference. She said that she did tell LVN B, that she needed to take the pill for herself because she was short. She carried the pill with her and went back to the unit. However, the more she thought about it, the more she realized she couldn't take it. LVN B reports that she then put the medication in a sharps container so that it would be destroyed. She also said that there was someone else on the unit at the time that saw her place the pill in the sharp's container, but she didn't recall exactly who was there. Record review of the facility in-service dated 6/21/24 titled Medication administration policy: Do not take meds for personal use revealed: LVN A signed. During an interview on 6/25/24 at 2:30 PM, the DON stated LVN B notified the facility on 6/18/2024 that she received a letter from The Texas Board of Nursing that LVN B was being investigated for taking a resident's medication. The DON stated the medication that LVN B took from the medication cart was Synthroid. The DON stated LVN B told another nurse (LVN C), she was going to take the medication out of the medication cart and take it for herself. The DON stated LVN B told her she decided to not take the pill and discarded it in the sharps container. During an interview on 6/25/24 at 4:47 PM, LVN C stated she was the charge nurse on the shift and had passed out medications, but she could not remember the date. She stated she parked the medication cart on south hall by the dining room when she stepped away to deal with another resident. She stated she turned around and saw LVN B in her medication cart. She said she had asked LVN B what she was doing and LVN B told her she was taking Resident #1's Levothyroxine because she had the same prescription at home but was short on her pills. She stated she observed LVN B pop the pill in her mouth, then she walked to the back of the facility. She stated LVN B was able to gain access to the medication cart because she left it unlocked. She stated she was not supposed to leave it unlocked. She stated staff were not supposed to take medications from the cart for personal use. During an interview on 6/25/24 at 6:15 PM, LVN B stated she had a prescription for Levothyroxine 150mg but needed to take 175mg pill, and off the top of her head she thought she would take one of Resident #1 Levothyroxine pills out of the medication cart. LVN B stated she walked to the front lobby and saw the medication cart and it was unlocked. She stated she took the pill and walked away. LVN B stated when she returned to her unit, she decided to not take the pill and placed it in the sharps container. She stated she had been trained on misappropriation and that she should not have taken the pill out of the medication cart. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 3:26 PM, the DON stated LVN C told her that LVN B told hershe had taken medication from LVN C's medication cart. The DON stated staff are not supposed to take or borrow medications from residents for personal use. She stated LVN C told her she had witnessed LVN B take the medication. Record review of the facility in-service undated topic Do not borrow meds from other resident to give to another resident or for personal use. Follow facility protocol. Follow medication administration procedure. Be survey ready. Mock survey 6/25/2024. Keep medication cart locked. revealed: the DON and 2 other staff signed on 5/5/24; LVN B and the ADON signed on 5/6/24; LVN C signed on 5/8/2024. Record review of the facility in-service dated 6/25/24 titled Abuse/Neglect/Exploitation/Misappropriation provided to staff. Record review of the facility in-service dated 6/25/24 titled Abuse, and neglect, and reporting revealed: signed by DON and ADM A. During an interview on 6/26/24 at 1:37 PM, Admin D, stated he spoke with LVN B about the letter she had received from the BON and the details in the letter, one was an allegation that she had taken a resident's certain medication. The Admin D stated LVN B was short of her own medication and she borrowed from the resident to make up for herself . Admin D stated he reported the incident to HHSC. The facility in serviced staff and LVN B was suspended pending investigation. Record review of facility provided policy titled, Abuse, Neglect, and Exploitation dated 10/2023, revealed: The facility will provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation and misappropriation of resident property. Prevention of Abuse, Neglect and Exploitation: The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect and misappropriation of resident property and exploitation that achieves: B. Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the residents' care needs and behavioral symptoms. F. Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution, and providing feedback regarding the concerns that have been expressed. G. Addressing features of the physical environment that may make abuse, neglect, and exploitation, and misappropriation of resident property more likely to occur. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	H. Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. Identification of Abuse, Neglect, and Exploitation: B. Possible indicators of abuse include, but are not limited to 8. Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning and positioning . Investigation of Alleged Abuse, Neglect, and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur B. Written procedures of investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence) 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent and cause, and 6. Providing complete and thorough documentation of the investigation. Protection of Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation; B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; C. Increased supervision of the alleged victim and residents; D. Room or staff changes, if necessary, to protect the resident(s) from the alleged perpetrator; E. Protection from retaliation; (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Providing emotional support and counseling to the resident during and after the investigation, as needed, and G. Revision of the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change because of an incident of abuse. Reporting/Response: 5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to the following: a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property, or exploitation occurred and what changes are needed to prevent future occurrences.

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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 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** 49154 Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 8 residents (Resident #2) reviewed for accidents. The facility failed to use an appropriate transfer for Resident #2 which resulted in a fall for Resident #2 and caused Resident #2's surgical wound from a below the right knee amputation to bleed. This failure could place residents at risk for harm and further injuries. The findings included: Record review of Resident #2's undated face sheet reflected Resident #2 was a [AGE] year-old male whose current admitted was on 2/4/2021, and a readmission to the facility on [DATE]. Resident #2 had the following diagnoses: chronic obstructive pulmonary disease (airflow blockage and breathing-related problems), muscle weakness, acquired absence of right leg below knee (partial amputation of the right leg), complete traumatic amputation at knee level, left lower leg, subsequent encounter (partial amputation of the left leg), unspecified systolic (congestive) heart failure (heart condition), essential primary hypertension (high blood pressure), mood disorder (mental health condition), Anxiety disorder due to known physiological condition (mental health condition), and chronic kidney disease (gradual loss of kidney function). Record review of Resident #2's clinical record reflected his comprehensive MDS assessment was completed on 4/10/2024 listing him with a BIMS score of 13, which indicated he was moderately cognitively intact. Additionally, section GG - Functional Abilities and Goals revealed Resident #2 is dependent- requires supervision or touching assistance - Helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity. For chair/bed-to-chair transfers. Record review of Resident #2's physician orders dated 4/01/24 to 4/30/24 revealed an order dated 4/09/24 to maintain ace bandage to right stump until appointment on 4/17/20 and to monitor for bleeding and signs of complication during every shift. Physician orders further revealed an order dated 4/23/24 to change dressing to stump 3 times a week and to monitor for bleeding and signs of complication during every shift. Record Review of Resident #2's Care Plan, dated 4/25/24, revealed Resident #2 had a below the knee amputation. Interventions included the use of a sliding board for transfers or mechanical lift for transfers PRN. Evaluation notes dated 06/19/24 revealed Resident #2 was able to transfer themselves from the bed to the wheelchair with or without the use of a sliding board and that Resident #2 declined to use the mechanical lift. Record review of Resident #2's progress notes from 4/1/24 to 6/26/24 revealed no documentation of the fall described by the resident or facility staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 12:03 PM the DON stated LVN B presented her with a letter she received in the mail from the Texas Board of Nursing that stated she was being investigated for allowing a resident to fall causing an injury. The DON stated she was not aware the allegations listed in the letter against LVN B until being shown the letter as it was not reported to her by staff or the resident. During an interview on 6/25/24 at 1:37 PM, Admin D stated he spoke with LVN B about the letter she had received from the BON and the details in the letter, one was an allegation of an improper transfer that resulted in a fall. He stated the LVN B did try to transfer a resident and a fall happened. During an interview on 6/25/24 at 2:16 PM the corporate nurse stated she could not locate any documentation or any other records in the electronic health record referencing the fall involving Resident #2 and LVN B. During an interview on 6/25/24 at 3:36 PM, CNA E stated she witnessed LVN B and Resident #2 fall during a transfer. She stated she was not able to determine the date or time frame of when this incident occurred, but she believed it was shortly after Resident #2's surgery of when his leg was amputated a couple of months ago. She stated she could not recall the time of when it occurred, but she believed it would have happened between 3:00 PM and 7:00 PM. She stated on the day of the incident she, CNA F, and another staff were all asked to go into Resident #2's bedroom to assist with transferring him from the wheelchair to his bed. LVN B was asked if they were going to use the mechanical lift and LVN B replied she was going to transfer Resident #2 by bear hugging him and lifting him from the wheelchair to the bed. CNA E stated she observed LVN B bear hug Resident #2 face to face, then she stumbled backwards while lifting him, and then both she and Resident #2 fell backwards into a refrigerator, and then onto the floor. CNA E stated Resident #2 hit the incision on his right leg on the floor then it started to bleed. CNA E stated Resident #2 was on top of LVN B CNA E with his arms around her and his legs straddled around her body. CNA E stated she could not recall how LVN B got out from under resident #2. CNA E stated afterwards, they all worked together to lift Resident #2 off the ground and onto his bed. CNA E stated she left about 10 minutes later to return to her assigned hall to assist other residents. CNA E stated Resident #2 has never refused a transfer with a sliding board or the mechanical lift. CNA E stated Resident #2 used the sliding board to transfer himself or instructed staff to push his chair against his bed to transfer himself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 3:54 PM CNA F stated she witnessed LVN B and Resident #2 fall during a transfer. She stated she could not determine the date or time frame of when this incident occurred, but she believed it was shortly after Resident #2's surgery of when his leg was amputated a couple of months ago (04/2024). CNA F stated she believed the incident occurred before 7:00 PM on the day it occurred. CNA F stated Resident #2 used his call light and told her he needed assistance with a transfer from his wheelchair to his bed. CNA F stated LVN B had transferred Resident #2 into his wheelchair earlier that day, so she understood that was why she was responsible to transfer him back to his bed. CNA F stated LVN B bear-hugged Resident #2 and picked him up from his wheelchair and stumbled and fell back into the refrigerator, and then they both fell on to the floor. CNA F stated they all helped get Resident #2 up and into bed by grabbing under his legs and arms and his leg when she saw blood on his leg. CNA F stated LVN B then went to get supplies for the blood and called the DON. CNA F stated the DON came and helped put new dressing on Resident #2's leg. CNA F stated Resident #2 moaned and made noises but did not say anything. CNA F stated Resident #2 asked about the blood, but he had not say he was in pain. CNA F stated she could not remember how LVN B got Residents #2 off her. CNA F stated Resident #2 was not taken to the hospital nor was emergency assistance called after the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 4:47 PM, LVN C stated she was the charge nurse on the day LVN B and Resident #2 fell during a transfer. She stated she could not to determine the date or time frame of when this incident occurred, but she believed it may have been on a day that was not her regular workday that she came in to fill a shift. She stated the incident may have been two or three days after Resident #2's surgery of when his leg was amputated a couple of months ago. She stated she was aware that Resident #2's surgical incision had been bleeding when he readmitted from the hospital. She stated Resident #2 wanted to get in his wheelchair, but he refused to be transferred with the lift. She stated staff told Resident #2 that they must use the lift for transfers, but he refused again. She stated she had not wanted to transfer Resident #2 as it would not have been safe to transfer him without the lift. She stated she had been concerned that there would not have been any male staff on shift in the evening to help put him back in bed. LVN C stated she went on her lunch break. She stated she observed Resident #2 in his wheelchair when she returned from her lunch break. She stated staff told her that Resident #2 asked LVN B to transfer him into his wheelchair when she had walked by coming back from a smoke break. LVN C stated Resident #2 was ready to get back in bed later that evening, so she told CNA F to get LVN B, who was the charge nurse on a different unit, and to tell her she needed to put Resident #2 back in bed, and then she went to chart records. She stated LVN B approached her and asked why her staff could not complete the transfer, in which she replied to LVN B that since she was the one to take him out of bed then she needed to figure out how to put him back in bed. LVN C stated LVN B walked away. LVN C stated she had been charting records when she heard a loud commotion. She stated CNA E, CNA F, and another staff came and told her that LVN B hit the refrigerator and dropped Resident #2 on the floor. She stated LVN B said she called the DON due to the blood. She stated staff went to get supplies and the DON arrived about that time. She stated she observed blood on his bed the size of a soccer ball and that his bandage was soaked with blood. She stated the DON called the surgeon and was advised to monitor the incision for infection, and to call back if infection appeared. She stated she then left for the evening. She stated Resident #2 had not been taken to the hospital for this incident. She stated the next day, she was told not to document the incident in the post log by the DON because it was considered a transfer and not a fall. She stated there had not been any documentation completed to record the incident. She stated she helped apply the new dressing and observed the incision to be opened about one inch. She stated she helped put pressure on the incision and put a bandage on it. She stated she helped apply gauze and they were able to get the bleeding to stop after wrapping it for the third time. She stated Resident #2 already had an appointment that was scheduled shortly after (possibly a week's time), and that was the first time the incision was observed by a physician after the incident. She stated they received new orders from the physician and that they physician applied additional dressing on it. She stated at that time, there was not an order to use a mechanical lift for transfers, but she felt it was best to use it. She stated Resident #2 seemed to like to use the sliding board for transfers and that he refused the mechanical lift. Record review of a facility in-service dated 6/19/24 titled Falls and use of gait belt revealed: 26 staff signed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of letter signed by ADM D on 6/20/24 titled LVN B Interview revealed: I interviewed LVN B on June 20, 2024. In response to the allegations contained in the letter that she received from the Board of Nursing, she reported the following: 2. As to Resident #2's fall, LVN B told me that she was working on the secured unit when the aides came and asked for her help in transferring Resident #2 into his bed. She had successfully transferred him to his wheelchair earlier that day. She left the unit to help them with the transfer. She entered Resident #2's room and attempted to lift him from his chair and into his bed. As she was doing this, he began kicking the stumps of his legs and this threw her off balance. She stumbled backwards and both of them landed on the floor with him on top of her. His brief was soaked with urine, and it went all over her scrubs. After that she helped the aides get him off the floor and into his bed. His stump was bleeding, and she told LVN C, his charge nurse about it bleeding. LVN C told LVN B that she had urine all over her and she shouldn't be changing his dressing. LVN B then gathered the supplies she needed and went to change Resident #2's dressing. LVN B then returned to the secured unit. She did not call the D.O.N. at that time to come in to help with the dressing. LVN B said she did call the DON the day that Resident #2 returned from the hospital after his amputation. He needed his dressing changed and she wasn't sure how to change it properly. She called the DON, and the DON came to the facility and helped her change the dressing. This was prior to when the fall occurred. The fall occurred one afternoon while the DON came to the facility on e night to help with the dressing change . Record review of competency skills checklist and competency evaluation form dated 6/21/24 revealed LVN B demonstrated competencies met on transfers from bed to wheelchair using transfer belt and slide board transfer. LVN B also demonstrated competencies met on all but one competency on the assessment for lifting machine, using a mechanical. Record review of the facility in-service dated 6/24/24 titled Slide board transfer training revealed: 8 staff signed. Record review of the facility in-service dated 6/25/24 titled Abuse/Neglect/Exploitation/Misappropriation revealed: 22 staff signed. Record review of the facility in-service dated 6/25/24 titled Abuse, and neglect, and reporting revealed: 2 staff signed. Record review of letter signed by LVN C on 6/19/24 titled LVN C Interviewed revealed: On June 29, 2024, at approximately 1 :45 p.m., I interviewed LVN C about any information she may have concerning the allegations the facility had received about LVN B . LVN B also said that she was aware of Resident #2 falling soon after returning from the hospital from having his leg amputated. She stated that earlier in the day, LVN B had transferred him without using a lift. Resident #2 does not like to use the lift for transfer. Later in the day, he wanted to transfer again. LVN B again came to transfer him by herself without using a lift. At this time, when she lifted him, she stumbled backwards, hit the small refrigerator in his room, and both of them fell to the floor. She said that CNA F, CNA E, and another CNA had witnessed the fall. She had not. During an interview on 6/25/24 at 5:47 PM ADM A stated a bear hug transfer was an improper transfer and that staff were not trained to complete bear hug transfers on residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/25/24 at 5:55 PM, the Corporate Nurse stated their policy did not instruct staff to use bear hug transfers and that staff should not have done a bear hug transfer on Resident #2. She stated she was not able to locate any documentation referencing the fall. She stated LVN C was the charge nurse on Resident #2's hall and LVN B was the charge nurse on a different unit during the time of that incident. She stated she was able to determine LVN C was on lunch when LVN B transferred Resident #2 to his wheelchair that day. She stated LVN B was his preferred staff, so she helped. She stated he did not like the mechanical lift and sometimes he did not like use the sliding board for transfers. She stated they could not determine when it happened. She stated Resident #2 has said the lift chokes him and he refuses it. She stated a bear hug was not an appropriate transfer. She stated in that situation, she would have done a two person transfer with a sheet due to his weight. During an interview on 6/25/24 at 5:55 PM, the DON stated she used an Ace bandage and the bleeding resolved. She stated there was nothing more she needed to do. The DON she would not have transferred Resident #2 that day, but she cannot speak for LVN B on why she transferred him. She stated she preferred for Therapy to evaluate him before he was transferred, but they were not there that day. She stated it was not required for Therapy to assess the resident before he can be transferred but she would have used the mechanical lift instead. She stated LVN B was not told to transfer him that way. During an interview on 6/25/24 at 6:15 PM, LVN B stated she could not recall the date of the fall with Resident #2 but recalled the fall. LVN B stated staff asked her to transfer Resident #2 to bed. She stated she went in the room and Resident #2 refused the Hoyer, so she decided to lift him on her own. LVN B stated she stood in front of Resident #2 and he bear hugged her. LVN B stated, Resident #2 placed his arms around her neck and she placed her arms under his arms around his body and she lifted him up. LVN B stated, she stepped backwards lost her balance and fell and Resident #2 landed on top of her, straddling her. She stated Resident #2 pushed himself up with his hands and she scooted out from under him. She stated three staff assisted him off the floor and back in bed. LVN B stated Resident #2's stump was bleeding. She stated she had been trained on how to complete a proper transfer, but Resident #2 refused the Hoyer and she attempted to lift him herself to transfer him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/26/24 at 1:00 PM, Resident #2 stated he recalled a fall where LVN B transferred him from his chair to his bed. Resident #2 stated he could not recall the date of this fall. Resident #2 stated LVN B transferred him by herself, without assistance from another staff. Resident #2 stated LVN B instructed him to put his arms around her, and LVN B wrapped her arms around his torso and lifted him. Resident #2 stated LVN B was supposed to turn and place him on the bed, but LVN B lost her balance and fell back, into his refrigerator. Resident #2 stated he fell on top of LVN B, straddling her. Resident #2 stated he was face to face with LVN B and was very close to her. Resident #2 stated he scooted himself off LVN B by pushing himself with his hands on LVN B's stomach until he reached the floor, in between LVN's legs. Resident #2 stated he hit both of his legs, on his stumps, when he fell with LVN B. Resident #2 stated it was painful on his right leg that had been recently amputated. Resident #2 stated the incision site, on his right leg bled after the fall, but he stated that it was not a lot. Resident #2 stated the DON and LVN B checked the incision site on his right leg and changed the dressings. Resident #2 stated he was usually transferred with two staff, using a sliding board. Resident #2 stated he did not like using the Hoyer lift because he felt claustrophobic and [NAME] as if he was choking. Resident #2 stated he could not remember exactly who was present during the fall, but he recalled CNA E, was present. Resident #2 stated LVN B did not ask for help when she transferred him from the CNA's that were present, and he did not know why. Resident #2 stated LVN B said she thought she could do it on her own, and he thought she could do it also. Resident #2 stated he has never been transferred by just one person before. Resident #2 stated LVN B did not say anything to him after the fall. During an interview on 6/26/24 at 1:59 PM, the COTA was asked if she would consider Resident #2 to be a safe one-person transfer and she stated, Absolutely not, it would not be safe. He was too heavy, and it could hurt the resident or myself. The COTA stated Resident #2 should never be transferred using a bear hug method due to having bilateral below the knee amputations and not being able to pivot to assist the person transferring him. Record review of facility provided policy titled, Falls and Fall Risks, Managing dated 07/2019, revealed: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation Definition: According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor, or other lower level, but not a s a result of an overwhelming external force (e.g. a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Challenging a resident's balance and training him/her to recover form loss of balance is an intentional therapeutic intervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall. Fall Risk Factors: 1. Environmental factors that contribute to the risk of falls include: a. Wet floors; b. Poor lighting; c. Incorrect bed height or width; d. Obstacles in the footpath e. Improperly filled or maintained wheelchairs, and f. Footwear that is unsafe or absent 2. Resident conditions that may contribute to the risk of falls include: a. Fever; b. Infection; c. Delirium and other cognitive impairment; d. Pain; e. Lower extremity weakness; f. Poor grip strength; g. Medication side effects; h. Orthostatic hypotension; i. Functional impairments; j. Visual deficits, and k. Incontinence 3. Medical factors that contribute to the risk of falls include: a. Arthritis; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. Heart failure; c. Anemia; d. Neurological disorders; and e. Balance and gait disorders; etc. Resident Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Monitoring Subsequent Falls and Fall Risk 1. The staff with monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. Record review of facility provided policy titled, Assessing Falls and Their Causes dated 3/2018, revealed: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Steps in the Procedure After a Fall: 3. If there is evidence of injury, provide appropriate first aid and obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position, and then document relevant details. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 7. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Defining Detains of Falls: 1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. For each individual, distinguish falls in the following categories: a. Rolling, sliding or dropping from an object (e.g., from bed or chair or floor) b. Falling while attempting to stand up from a sitting or lying position, or c. Falling while already standing and trying to ambulate Identifying Causes of a Fall or Fall Risk 1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident specific chains of events or circumstances proceeding a recent fall, including : a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. whether any environmental risk factors were involved (e.g. slippery floor, poor lighting, furniture, or objects in the way) and/or g. Whether the resident was trying to get to the toilet h. whether there is a pattern of this balls for this resident 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. 4. as indicated, the attending physician will examine the resident or may initiate testing to try to identify causes. 5. consult with the attending physician or medical director to confirm specific causes from among multiple possibilities. when possible, document the basis for identifying specific factors as the cause. 6. if the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g. workup already done, finding A cause would not change the approach, etc.). Documentation When a resident falls, the following information should be recorded in the residence medical record: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. The condition in which the resident was found (e.g resident found lying on the floor between bed and chair) 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a fall risk assessment. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. Reporting 1. Notify the following individuals when a resident falls: a. The resident's family b. The attending physician (timing of notification may vary depending on whether injury was involved); c. The director of nursing services and d. The nursing supervisor on duty 2. Report other information in accordance with facility policy and professional standards of practice. Record review of facility provided policy titled, Falls - Clinical Protocol dated 3/2018, revealed: Assessment and recognition: 2. In addition, the nurse shall assess and document/report the following: a. Vital signs; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in condition or level of consciousness; e. Neurological status; f. pain; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	g. Frequency and number of falls since the last position visit; h. Precipitating factors; details on how far all occurred; i. All current medications, especially those associated with dizziness or lethargy; and j. All active diagnosis 5. The staff will evaluate and document falls that occur while they invent individual is in the facility, for example when and where they happen, any observations of the event, etc. 6. All should be categorized as: a. Those that occur while trying to rise from a sitting or lying to an upright position; b. Those that occur while upright and attempting to ambulate; and c. Other circumstances such as sliding out of a chair or rolling from a low bed on the floor 7. Falls should also be identified as witnessed or unwitnessed events Record review of facility provided policy titled, Fall Prevention - Potential Interventions dated 5/2019, revealed: Intervention: Assistive Devices; Description: Other Intervention: Mobility; Description: Review transfer status Record review of facility provided policy titled, Safe Lifting and Movement of Residents dated 3/31/2023, revealed: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation 1. resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of resident. 2. Manual lifting of residents shall be eliminated when feasible. 3. Nursing staff in conjunction with the real habilitation staff, shall assess individual residents needs 4 transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: a. Residents' preferences for assistance, b. Residents' mobility (degree of dependency), (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. Resident size, d. Weight bearing ability, e. Cognitive status, f. Whether the resident is usually cooperative with staff, and g. The residents' goal for rehabilitation, including restoring or maintaining functional abilities. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/ transfer belts, lateral boards) and mechanical lifting devices. 5. Mechanical lifting devices shall be used for heavy lifting, including lifting, and moving residents when necessary. 6. Only staff with documented training on the safe use and care of the machines and equipment used in this facility will be allowed to lift or move residents. 7. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. 12. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which: a. involves employees in identifying problem areas and implementing workplace safety and injury prevention strategies; b. addresses reports of workplace injuries; c. provides training on safety, ergonomic and proper use of equipment, and d. continually evaluates the effectiveness of workplace safety and injury prevention strategies.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49154 Based on interview and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 2 medication carts (medication cart on front hall). The facility failed to ensure that medication 1 of 2 medication carts were secured when unattended on or about 4/21/2024 through 4/28/2024 and/or 5/2/2024. This failure could place residents at risk of having access to unauthorized medications and/or lead to possible harm, drug overdose, or drug diversions. Findings included: During an interview on 6/25/24 at 2:30 PM, the DON stated LVN B notified the facility she received a letter from The Texas Board of Nursing that LVN B was being investigated for taking a resident's medication. The DON stated the medication that LVN B took from the medication cart was Synthroid. The DON stated LVN B told another nurse (LVN C), she was going to take the medication out of the take and take it for herself. The DON stated LVN B told her she decided to not take the pill and discarded it in the sharps container. During an interview on 6/26/24 at 3:26 PM, the DON stated LVN C told her that LVN B told her she was going to take medication from her cart. The DON stated she did not know if LVN C left the cart unlocked, but it was not supposed to be unlocked when unattended. During an interview on 6/25/24 at 4:47 PM, LVN C stated she was the charge nurse on the shift and had passed out medications, but she could not remember the date. She stated she parked the medication cart on south hall by the dining room when she stepped away to deal with another resident. She stated she turned around and saw LVN B in her medication cart. She said she had asked LVN B what she was doing and LVN B told her she was taking Levothyroxine out of the cart because she had the same prescription at home but was short on her pills. She stated she saw that LVN B had more than one pill in her hand but did not know how many. She stated she observed LVN B swallow the pills, then she walked to the back of the facility. She stated LVN B was able to gain access to the medication cart because she left it unlocked. She stated she was not supposed to leave it unlocked. She stated staff were not supposed to take medications from the cart for personal use. Record review of the facility in-service undated topic Do not borrow meds from other resident to give to another resident or for personal use. Follow facility protocol. Follow medication administration procedure. Be survey ready. Mock survey 6/25/2024. Keep medication cart locked. revealed: the DON and 2 other staff signed on 5/5/24; LVN B and the ADON signed on 5/6/24; LVN B signed on 5/8/2024. Record review of the facility in-service dated 6/21/24 titled Medication administration policy: Do not take meds for personal use revealed: LVN B signed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility in-service dated 6/25/24 titled Abuse/Neglect/Exploitation/Misappropriation revealed: 24 staff signed. Record review of letter signed by ADM D on 6/20/24 titled LVN B Interview revealed: I interviewed LVN B on June 20, 2024. In response to the allegations contained in the letter that she received from the Board of Nursing, she reported the following: 3. I asked her about the allegation that she had taken a Levothyroxine pill for her own personal use. She replied that she takes Levo and her prescription calls for her to take 175 Mg. The meds she has at her home are only 150 MG, they're 25 Mg short of what she needs. She said that she did go to the med cart and took a resident's pill out of the cart because his are 25 Mg and would make up the difference. She said that she did tell LVN B, that she needed to take the pill for herself because her's were short. She carried the pill with her and went back to the unit. However, the more she thought about it, the more she realized she couldn't take it. LVN B reports that she then put the medication in a sharps container so that it would be destroyed. She also said that there was someone else on the unit at the time that saw her place the pill in the sharp's container, but she didn't recall exactly who was there. Record review of letter signed by LVN C on 6/19/24 titled LVN C Interviewed revealed: On June 29, 2024 at approximately 1:45 p.m., I interviewed LVN C about any information she may have concerning the allegations the facility had received about LVN B. LVN C reported there had been a day when she had left her med cart to get some supplies. When LVN C returned, LVN B was in her cart. LVN B told LVN C that she needed some of a resident's Levo. LVN B was short of hers and she had a medical condition. LVN C said she does not give that med, other nurses do, but LVN B had a pill her hand and told LVN C she had taken some. During an interview on 6/25/24 at 6:15 PM, LVN B stated she walked to the front lobby and saw the medication cart and it was unlocked. She stated that the medication cart belonged to LVN C, was unattended and unlocked. She stated that she had been trained to lock the medication cart anytime it is left unattended. Record review of facility provided policy titled, Administering Medications dated 4/2019, revealed: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 4. Medications are administered in accordance with prescriber orders, including any required time frame. 16. during administration of medications comma the medication card is kept closed and locked when out of site of the medication nurse or aid. It may be kept in the doorway of the residence room, with open drawers facing inward and all other sides closed. No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36954 Based on interview and record review the facility failed to ensure in accordance with accepted professional standards and practices, medical records maintained on each resident were accurately documented for 1 of 8 residents (Resident #1) reviewed for accuracy of records. LVN B failed to document a fall with injury in the medical record progress note for Resident #2. This failure could place residents at risk for not receiving needed care or treatment after an incident occurred. The findings included: Record review of Resident #2's undated face sheet reflected Resident #2 was a [AGE] year-old male whose current admitted was on 2/4/2021, and a readmission to the facility on [DATE]. Resident #2 had the following diagnoses: chronic obstructive pulmonary disease (airflow blockage and breathing-related problems), muscle weakness, acquired absence of right leg below knee (partial amputation of the right leg), complete traumatic amputation at knee level, left lower leg, subsequent encounter (partial amputation of the left leg), unspecified systolic (congestive) heart failure (heart condition), essential primary hypertension (high blood pressure), mood disorder (mental health condition), Anxiety disorder due to known physiological condition (mental health condition), and chronic kidney disease (gradual loss of kidney function). Record review of Resident #2's clinical record reflected his comprehensive MDS assessment was completed on 4/10/2024 listing him with a BIMS score of 13, which indicated he was moderately cognitively intact. Additionally, section GG - Functional Abilities and Goals revealed Resident #2 requires supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently for chair/bed-to-chair transfers. Record review of Resident #2's physician orders dated 4/01/24 to 4/30/24 revealed an order dated 4/09/24 to maintain ace bandage to right stump until appointment on 4/17/20 and to monitor for bleeding and signs of complication during every shift. Physician orders further revealed an order dated 4/23/24 to change dressing to stump 3 times a week and to monitor for bleeding and signs of complication during every shift. Record Review of Resident #2's Care Plan, dated 4/25/24, revealed Resident #2 had a below the knee amputation. Interventions included the use of a sliding board for transfers or mechanical lift for transfers PRN. Evaluation notes dated 06/19/24 revealed Resident #2 was able to transfer themselves from the bed to the wheelchair with or without the use of a sliding board and that Resident #2 declined to use the mechanical lift. Record review of Resident #2's progress notes from 4/1/24 to 6/26/24 revealed no documentation of the fall described by the resident or facility staff. (continued on next page)

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	675989	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brazos Valley Care Home	605 S Ave F Knox City, TX 79529

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 1:37 PM, Admin D stated he spoke with LVN B about the letter she had received from the BON and the details in the letter, one was an allegation of an improper transfer that resulted in a fall. He stated the LVN B did try to transfer a resident and a fall happened. During an interview on 6/25/24 at 2:16 PM the corporate nurse stated she could not locate any documentation or any other records in the electronic health record referencing the fall involving Resident #2 and LVN B. During an interview on 6/25/24 at 3:36 PM, CNA E stated she witnessed LVN B and Resident #2 fall during a transfer. She stated she was not able to determine the date or time frame of when this incident occurred, but she believed it was shortly after Resident #2's surgery of when his leg was amputated a couple of months ago. She stated she could not recall the time of when it occurred, but she believed it would have happened between 3:00 PM and 7:00 PM. She stated on the day of the incident she, CNA F, and another staff were all asked to go into Resident #2's bedroom to assist with transferring him from the wheelchair to his bed. LVN B was asked if they were going to use the mechanical lift and LVN B replied she was going to transfer Resident #2 by bear hugging him and lifting him from the wheelchair to the bed. CNA E stated she observed LVN B bear hug Resident #2 face to face, then she stumbled backwards while lifting him, and then both she and Resident #2 fell backwards into a refrigerator, and then onto the floor. CNA E stated Resident #2 hit the incision on his right leg on the floor then it started to bleed. CNA E stated Resident #2 was on top of LVN B CNA E with his arms around her and his legs straddled around her body. CNA E stated she could not recall how LVN B got out from under resident #2. CNA E stated afterwards, they all worked together to lift Resident #2 off the ground and onto his bed. CNA E stated she left about 10 minutes later to return to her assigned hall to assist other residents. CNA E stated Resident #2 has never refused a transfer with a sliding board or the mechanical lift. CNA E stated Resident #2 used the sliding board to transfer himself or instructed staff to push his chair against his bed to transfer himself. During an interview on 6/25/24 at 3:54 PM CNA F stated she witnessed LVN B and Resident #2 fall during a transfer. She stated she could not determine the date or time frame of when this incident occurred, but she believed it was shortly after Resident #2's surgery of when his leg was amputated a couple of months ago. CNA F stated she believed the incident occurred before 7:00 PM on the day it occurred. CNA F stated Resident #2 used his call light and told her he needed assistance with a transfer from his wheelchair to his bed. CNA F stated LVN B had transferred Resident #2 into his wheelchair earlier that day, so she understood that was why she was responsible to transfer him back to his bed. CNA F stated LVN B bear-hugged Resident #2 and picked him up from his wheelchair and stumbled and fell back into the refrigerator, and then they both fell on to the floor. CNA F stated they all helped get Resident #2 up and into bed by grabbing under his legs and arms and his leg when she saw blood on his leg. CNA F stated LVN B then went to get supplies for the blood and called the DON. CNA F stated the DON came and helped put new dressing on Resident #2's leg. CNA F stated Resident #2 moaned and made noises but did not say anything. CNA F stated Resident #2 asked about the blood, but he had not say he was in pain. CNA F stated she could not remember how LVN B got Residents #2 off her. CNA F stated Resident #2 was not taken to the hospital nor was emergency assistance called after the incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/24 at 4:47 PM, LVN C stated she was the charge nurse on the day LVN B and Resident #2 fell during a transfer. She stated she could not to determine the date or time frame of when this incident occurred, but she believed it may have been on a day that was not her regular workday that she came in to fill a shift. She stated the incident may have been two or three days after Resident #2's surgery of when his leg was amputated a couple of months ago. She stated she was aware that Resident #2's surgical incision had been bleeding when he readmitted from the hospital. She stated Resident #2 wanted to get in his wheelchair, but he refused to be transferred with the lift. She stated staff told Resident #2 that they must use the lift for transfers, but he refused again. She stated she had not wanted to transfer Resident #2 as it would not have been safe to transfer him without the lift. She stated she had been concerned that there would not have been any male staff on shift in the evening to help put him back in bed. LVN C stated she went on her lunch break. She stated she observed Resident #2 in his wheelchair when she returned from her lunch break. She stated staff told her that Resident #2 asked LVN B to transfer him into his wheelchair when she had walked by coming back from a smoke break. LVN C stated Resident #2 was ready to get back in bed later that evening, so she told CNA F to get LVN B, who was the charge nurse on a different unit, and to tell her she needed to put Resident #2 back in bed, and then she went to chart records. She stated LVN B approached her and asked why her staff could not complete the transfer, in which she replied to LVN B that since she was the one to take him out of bed then she needed to figure out how to put him back in bed. LVN C stated LVN B walked away. LVN C stated she had been charting records when she heard a loud commotion. She stated CNA E, CNA F, and another staff came and told her that LVN B hit the refrigerator and dropped Resident #2 on the floor. She stated LVN B said she called the DON due to the blood. She stated staff went to get supplies and the DON arrived about that time. She stated she observed blood on his bed the size of a soccer ball and that his bandage was soaked with blood. She stated the DON called the surgeon and was advised to monitor the incision for infection, and to call back if infection appeared. She stated she then left for the evening. She stated Resident #2 had not been taken to the hospital for this incident. She stated the next day, she was told not to document the incident in the post log by the DON because it was considered a transfer and not a fall. She stated there had not been any documentation completed to record the incident. She stated she helped apply the new dressing and observed the incision to be opened about one inch. She stated she helped put pressure on the incision and put a bandage on it. She stated she helped apply gauze and they were able to get the bleeding to stop after wrapping it for the third time. She stated Resident #2 already had an appointment that was scheduled shortly after (possibly a week's time), and that was the first time the incision was observed by a physician after the incident. She stated they received new orders from the physician and that they physician applied additional dressing on it. She stated at that time, there was not an order to use a mechanical lift for transfers, but she felt it was best to use it. She stated Resident #2 seemed to like to use the sliding board for transfers and that he refused the mechanical lift. During an interview on 6/25/24 at 6:15 PM, LVN B stated she could not recall the date of the fall with Resident #2 but recalled the fall. LVN B stated staff asked her to transfer Resident #2 to bed. She stated she went in the room and Resident #2 refused the Hoyer, so she decided to lift him on her own. LVN B stated she stood in front of Resident #2 and he bear hugged her. LVN B stated, Resident #2 placed his arms around her neck and she placed her arms under his arms around his body and she lifted him up. LVN B stated, she stepped backwards lost her balance and fell and Resident #2 landed on top of her, straddling her. She stated Resident #2 pushed himself up with his hands and she scooted out from under him. She stated three staff assisted him off the floor and back in bed. LVN B stated Resident #2's stump was bleeding. She stated she had been trained on how to complete a proper transfer, but Resident #2 refused the Hoyer and she attempted to lift him herself to transfer him. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 1:00 PM, Resident #2 stated he recalled a fall where LVN B transferred him from his chair to his bed. Resident #2 stated he could not recall the date of this fall. Resident #2 stated LVN B transferred him by herself, without assistance from another staff. Resident #2 stated LVN B instructed him to put his arms around her, and LVN B wrapped her arms around his torso and lifted him. Resident #2 stated LVN B was supposed to turn and place him on the bed, but LVN B lost her balance and fell back, into his refrigerator. Resident #2 stated he fell on top of LVN B, straddling her. Resident #2 stated he was face to face with LVN B and was very close to her. Resident #2 stated he scooted himself off LVN B by pushing himself with his hands on LVN B's stomach until he reached the floor, in between LVN's legs. Resident #2 stated he hit both of his legs, on his stumps, when he fell with LVN B. Resident #2 stated it was painful on his right leg that had been recently amputated. Resident #2 stated the incision site, on his right leg bled after the fall, but he stated that it was not a lot. Resident #2 stated the DON and LVN B checked the incision site on his right leg and changed the dressings. Resident #2 stated he was usually transferred with two staff, using a sliding board. Resident #2 stated he did not like using the Hoyer lift because he felt claustrophobic and [NAME] as if he was choking. Resident #2 stated he could not remember exactly who was present during the fall, but he recalled CNA E, was present. Resident #2 stated LVN B did not ask for help when she transferred him from the CNA's that were present, and he did not know why. Resident #2 stated LVN B said she thought she could do it on her own, and he thought she could do it also. Resident #2 stated he has never been transferred by just one person before. Resident #2 stated LVN B did not say anything to him after the fall. Record review of facility provided policy titled, Assessing Falls and Their Causes dated 3/2018, revealed: The purpose of this procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Steps in the Procedure After a Fall: 3. If there is evidence of injury, provide appropriate first aid and obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position, and then document relevant details. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 1. Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. Defining Detains of Falls: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred. 2. For each individual, distinguish falls in the following categories: a. Rolling, sliding or dropping from an object (e.g., from bed or chair or floor) b. Falling while attempting to stand up from a sitting or lying position, or c. Falling while already standing and trying to ambulate Identifying Causes of a Fall or Fall Risk 1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident specific chains of events or circumstances proceeding a recent fall, including : a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. whether any environmental risk factors were involved (e.g. slippery floor, poor lighting, furniture, or objects in the way) and/or g. Whether the resident was trying to get to the toilet h. whether there is a pattern of this balls for this resident 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. 4. as indicated, the attending physician will examine the resident or may initiate testing to try to identify causes. 5. consult with the attending physician or medical director to confirm specific causes from among multiple possibilities. when possible, document the basis for identifying specific factors as the cause. 6. if the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (e.g. workup already done, finding A cause would not change the approach, etc.). Documentation (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When a resident falls, the following information should be recorded in the residence medical record: 1. The condition in which the resident was found (e.g resident found lying on the floor between bed and chair) 2. Assessment data, including vital signs and any obvious injuries. 3. Interventions, first aid, or treatment administered. 4. Notification of the physician and family, as indicated. 5. Completion of a fall risk assessment. 6. Appropriate interventions taken to prevent future falls. 7. The signature and title of the person recording the data. Reporting 1. Notify the following individuals when a resident falls: a. The resident's family b. The attending physician (timing of notification may vary depending on whether injury was involved); c. The director of nursing services and d. The nursing supervisor on duty 2. Report other information in accordance with facility policy and professional standards of practice. Record review of facility provided policy titled, Falls - Clinical Protocol dated 3/2018, revealed: Assessment and recognition: 2. In addition, the nurse shall assess and document/report the following: a. Vital signs; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in condition or level of consciousness; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Neurological status; f. pain; g. Frequency and number of falls since the last position visit; h. Precipitating factors; details on how far all occurred; i. All current medications, especially those associated with dizziness or lethargy; and j. All active diagnosis 5. The staff will evaluate and document falls that occur while they invent individual is in the facility, for example when and where they happen, any observations of the event, etc. 6. All should be categorized as: a. Those that occur while trying to rise from a sitting or lying to an upright position; b. Those that occur while upright and attempting to ambulate; and c. Other circumstances such as sliding out of a chair or rolling from a low bed on the floor 7. Falls should also be identified as witnessed or unwitnessed events.