STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676000	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 of 4 residents (Resident #1) reviewed for neglect. The facility failed to develop and implement a written abuse and neglect policy for reporting abuse or neglect causing serious bodily injury immediately, but no later than 2 hours to the State Survey Agency (THHSC) which resulted in a failure to report an allegation of neglect with serious bodily injury of Resident #1. This failure could place all residents at risk for potential abuse due to unreported allegations of abuse. The findings included: Record review of a face sheet dated 08/7/2024 indicated Resident #1 was [AGE] years old, initially admitted to the facility on [DATE]. Her diagnoses included atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (occurs when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body (arteries) become thick and stiff - sometimes restricting blood flow to the organs and tissues causing chest pain), encounter for palliative care (care given to improve the quality of life of patients who have a serious or life-threatening disease), hypertensive heart disease with heart failure (heart disease caused by chronically high blood pressure), chronic systolic (congestive) heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), peripheral vertigo, dementia (loss of cognitive functioning) and anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of an MDS assessment dated [DATE] indicated Resident #1 was sometimes able to make herself understood and sometimes understands others. She had a BIMS score of 00 (severely impaired cognitively). She required bed and chair alarms (electronic devices) to monitor residents' movement and alert staff when movement is detected. She was dependent for most ADLs. She was always incontinent of bladder and bowel. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER: Pine Ridge Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE: 1620 US 59 N Livingston, TX 77351	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 06/02/2024 indicated Resident #1 had a risk for falls related to cognition and weakness and has fallen multiple times in the last 3 months. Interventions included to anticipate needs, provide prompt assistance; assure lighting is adequate and areas are free of clutter; encourage to ask for assistance of staff; encourage socialization and activities attendance; ensure call light is in reach and answer promptly; therapy to evaluate and treat per order; educate safety precautions; IDT to review fall risk every 90 days and after each fall; keep call light and frequently used items in reach; notify MD/family of falls; bed alarms when in bed; chair alarms when in use out of bed; continue to monitor incidents and update fall risk factors per policy and procedure; do not leave spilled liquids on the floor; do not leave unattended on Gurney or shower chair; ensure wearing nonskid socks and or shoes; ensure staff member are aware of fall risk; fall mats beside bed; follow facility fall protocol; use physical device for fall prevention; and monitor for signs and symptoms of Vertigo. Record review of Resident #1's progress note authored by LVN E indicated on 08/05/2024 at 5:00 p.m., the resident was found on the floor by aide, resident with laceration on left side of head and laying on floor. Laceration actively bleeding, pressure and dressing applied. Notified EMS for pickup two local ER for evaluation and treatment Hospice and emergency contact notified. Record review of Resident #1's progress note authored by RN B indicated on 08/05/2024 at 5:29 p.m., CNA had just walked out of room, heard noise and walked back found resident on floor laying on left side with large pool of blood under her head. She checked her over found large deep laceration to left temple and held pressure no other lacerations found but resident yelling and swinging arms very combative, checked range of motion of arms and hips no pain with movement stayed with resident until EMS arrived. Record review of Resident #1's progress note authored by RN B indicated on 08/05/2024 at 8:35 p.m., she was notified Resident #1 had sustained a brain bleed during the fall and had been transferred to [name of city] hospital for treatment. During an interview on 08/07/2024 at 1:45 p.m., RN B said she was the charge nurse for Hall 3 (Resident #1's hall) on 08/05/2024 evening shift. She said around 5:00 p.m. she was summoned to Resident #1's room due to resident found on floor (unwitnessed fall) by CNAs. RN B said she completed an assessment and found Resident #1 to have a laceration to left forehead requiring evaluation and treatment. RN B said she applied pressure to laceration and provided pressure dressing and EMS activated. RN B said once Resident #1 was transferred to local ER for evaluation, she completed her documentation and notified the DON (on call management staff) of Resident #1's unwitnessed fall and transfer to local ER. RN B said she later received a call Resident #1 was being transferred to a higher level of care hospital for treatment of a subdural hematoma/hemorrhage. RN B said she texted the DON (on call management staff) with the updated information on 08/05/2024 at 8:30 p.m. when she was made aware. RN B said unwitnessed fall and fall with injury must be reported to management staff immediately to determine if incident is state reportable. RN B said once the incident is reported to management staff, they review the incident to determine if incident must be reported to the state. RN B said she was aware of state reportable time frames for incidents and allegations. RN B said fall with subdural hematoma/hemorrhage would be considered serious bodily injury and should be reported to the state agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 2:15 p.m., LVN E said had received training regarding abuse and neglect and that all allegation of abuse and/or neglect was to be reported to DON, Social Worker/Abuse Coordinator, Administrator or manger on call if after hours. LVN E said they give report and management determines when and if the allegation must be reported to state. LVN E said that during training they emphasized about reporting incidents/allegations immediately because some allegations have a 2-hour window to report to state. During an interview on 08/07/2024 at 2:38 p.m., CNA A said on 08/05/2024 at 4:45 p.m. she found Resident #1 on the floor in her room after hearing a noise and faint ouch, and she immediately went to Resident #1's room found resident lying on her left side with glasses on and bleeding from head. CNA A said she hollered for help and CNA C responded and summoned help from CN. CNA A said both CN's (RN B and LVN E) responded immediately. CNA A said Resident #1 was alert and saying her head hurt, she was swinging her arms and not wanting CN to apply pressure to laceration on forehead. CNA A said they were trying to calm her down by talking to her and holding her hands while CN completed assessment. CNA A said she was trained by facility that all falls were to be reported to CN immediately and once CN completed assessment, they dictated what to do next (send to hospital, get back to bed, etc.). CNA A said that CN would report to upper management if needed. CNA A said that if allegation of abuse occurred would report to CN, DON, Abuse Coordinator or ADM. CNA A said during training they emphasized Social Worker or Abuse Coordinator needed to be notified immediately of any allegations of abuse or serious bodily injury. During an interview on 08/07/2024 at 3:45 p.m., CNA C said she was trained by facility that all falls were to be reported to CN immediately, do not move resident and once CN completed assessment, they dictated what to do next (send to hospital, get back to bed, etc.). CNA C said that CN would report to upper management if needed. CNA C said that if allegation of abuse occurred would report to CN, DON, Abuse Coordinator or ADM. CNA C said during training they emphasized Social Worker/Abuse Coordinator needed to be notified immediately of any allegations of abuse or serious bodily injury. During an interview on 08/07/2024 at 4:15 p.m., the DON said he learned about the incident with Resident #1 on 08/06/2024 when he awoke to read a text message from RN B regarding Resident #1's fall on 08/05/2024 at 6:00 p.m. and another text message on 08/05/2024 at 8:30 p.m. Resident #1 has sustained a subdural hematoma/hemorrhage from fall and was being transferred to a higher left of care hospital. The DON said he was already asleep, and the text messages did not wake him up. The DON said the facility has changed the protocol and the facility staff must call the management on call with any incidents no text messaging. The DON said he should have notified the abuse coordinator or administrator immediately once he received the text or information regarding the severity of the injury from the fall. The DON said due to the severity of the injury sustained with the fall the injury/allegation should have been reported to the state immediately or within 2 hours once facility notified of the severity of the injury. The DON said that the current facility policy does not identify the state reporting timeframes for each incident type and needs to be updated. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pine Ridge Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE: 1620 US 59 N Livingston, TX 77351	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 5:15 p.m., the Abuse Coordinator said she was not made aware of Resident #1's fall with serious bodily injury until the next morning 08/06/2024 when she was reading her incident report emails. The Abuse Coordinator said the CN (RN B) notified the DON (manager on call) via text message of the incident and later the severity of the injury and he did not forward the information until 08/06/2024. The Abuse Coordinator said she completed the report to the state as soon as she was made aware of the incident and the severity of the injury on 8/6/2024 at 10:24 a.m. The Abuse Coordinator said the DON should have immediately notified her once he was aware of the incident and the severity of the injury, and she would have reported it to the state immediately or within 2 hours as required. The Abuse Coordinator was aware of reportable times for incident types of abuse (with or without serious bodily injury) or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury must be reported immediately but no later than two hours after the incident occurs or is suspected. The Abuse Coordinator said she uses THHSC long-term care regulatory provider letter PL 19-17 for guidance related to reporting abuse and neglect. The Abuse Coordinator said that the facility Abuse and Neglect policy did not identify and describe required reporting timeframes for incidents involving abuse (with or without serious bodily injury) or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury to be reported immediately but no later than 2 hours after the incident occurs or suspected to THHSC. The Abuse Coordinator said she uses THHSC long-term care regulatory provider letter PL 19-17 for guidance related to reporting abuse and neglect. During an interview on 08/07/2024 at 6:15 p.m., the Administrator said the expectations was for the facility staff to report all suspicions or allegations of abuse or neglect with serious bodily injury immediately to her and/or the abuse coordinator. She said the timeframe for reporting allegations of neglect with serious bodily injury to the state agency was to report within 2 hours of the allegation. The administrator said she or the designee should have reported allegations of abuse to the state agency within 2 hours of the allegation. The Administrator said she uses THHSC long-term care regulatory provider letter PL 19-17 for guidance related to reporting abuse and neglect. The Administrator said that the facility Abuse and Neglect policy did not identify and ensure reporting timeframes of crimes occurring in federally funded long-term care facilities in accordance with Social Security Act as required by state and federal regulations. Record review of TULIP intake for Resident #1 indicated information date received on 08/06/2024 at 10:24 a. m., read the allegation of neglect (fall) occurred on 08/05/2024 at 5:00 p.m. and resident was sent to local hospital for treatment and evaluation, and it was later determined at 08/05/2024 at 8:30 p.m. (14 hours prior) the fall had caused serious bodily injury (brain bleed) and was sent to a [name of city] hospital for treatment. Caller information indicates the reporter of the allegation was the Abuse Coordinator. (continued on next page)

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Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Abuse and Neglect and misappropriation policy dated 06/13/2023 indicated . B. Reporting 1. If an employee witnesses, is notified of or, suspects abuse, the following mandatory steps are taken a. ensure immediate safety of victim b. seek appropriate medical evaluation and treatment c. in cases of sexual and physical abuse protect all potential evidence: secure scene; sexual assault abuse victim must undergo medico-legal examination prior to bathing or changing clothes; identify witnesses; and secure evidence in locked areas. d. notify immediate supervisor, Administrator, Director of Nursing, and abuse coordinator e. notify physician f. report to law enforcement and adult Protective Services as mandated under Texas State law g. notify guardian, legal power of attorney or designated next of kin. h. complete incident report. The facility must ensure that all alleged violations involving mistreatment neglect or abuse including injuries of unknown source and misappropriation of resident property are reported immediately submitted to TDHS, [NAME] TX [PHONE NUMBER].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview and record review, the facility failed to ensure all alleged violations involving neglect that resulted in serious bodily injury of resident was reported immediately to the administrator or abuse coordinator and to THHSC within the 2-hour period for 1 of 4 residents (Resident #1) reviewed for neglect. The facility failed to ensure allegations of resident neglect with serious bodily injury were immediately reported to the administrator or abuse coordinator and to the State Agency no later than 2 hours after the incident occurred or was suspected. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated 08/7/2024 indicated Resident #1 was [AGE] years old, initially admitted to the facility on [DATE]. Her diagnoses included atherosclerotic heart disease of native coronary artery with other forms of angina pectoris (occurs when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body (arteries) become thick and stiff - sometimes restricting blood flow to the organs and tissues causing chest pain), encounter for palliative care (care given to improve the quality of life of patients who have a serious or life-threatening disease), hypertensive heart disease with heart failure (heart disease caused by chronically high blood pressure), chronic systolic (congestive) heart failure (a condition in which the heart's main pumping chamber (left ventricle) is weak), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), peripheral vertigo, dementia (loss of cognitive functioning) and anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #1 was sometimes able to make herself understood and sometimes understands others. She had a BIMS of 00 (severely impaired cognitively). She required bed and chair alarms (electronic devices) to monitor residents' movement and alert staff when movement is detected. She was dependent for most ADLs. She was always incontinent of bladder and bowel. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pine Ridge Health Care LLP		STREET ADDRESS, CITY, STATE, ZIP CODE 1620 US 59 N Livingston, TX 77351	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 06/02/2024 indicated Resident #1 had a risk for falls related to cognition and weakness and has fallen multiple times in the last 3 months. Interventions included to anticipate needs, provide prompt assistance; assure lighting is adequate and areas are free of clutter; encourage to ask for assistance of staff; encourage socialization and activities attendance; ensure call light is in reach and answer promptly; therapy to evaluate and treat per order; educate safety precautions; IDT to review fall risk every 90 days and after each fall; keep call light and frequently used items in reach; notify MD/family of falls; bed alarms when in bed; chair alarms when in use out of bed; continue to monitor incidents and update fall risk factors per policy and procedure; do not leave spilled liquids on the floor; do not leave unattended on Gurney or shower chair; ensure wearing nonskid socks and or shoes; ensure staff member are aware of fall risk; fall mats beside bed; follow facility fall protocol; use physical device for fall prevention; and monitor for signs and symptoms of Vertigo. Record review of Resident #1's progress note authored by LVN E indicated on 08/05/2024 at 5:00 p.m., the resident was found on the floor by aide, resident with laceration on left side of head and laying on floor. Laceration actively bleeding, pressure and dressing applied. Notified EMS for pickup two local ER for evaluation and treatment Hospice and emergency contact notified. Record review of Resident #1's progress note authored by RN B indicated on 08/05/2024 at 5:29 p.m., CNA had just walked out of room, heard noise and walked back found resident on floor laying on left side with large pool of blood under her head. She checked her over found large deep laceration to left temple and held pressure no other lacerations found but resident yelling and swinging arms very combative, checked range of motion of arms and hips no pain with movement stayed with resident until EMS arrived. Record review of Resident #1's progress note authored by RN B indicated on 08/05/2024 at 8:35 p.m., she was notified Resident #1 had sustained a brain bleed during the fall and had been transferred to Houston hospital for treatment. Record review of Resident #1's hospital records dated 08/05/2024 indicated transfer in from another hospital for a fall with forehead laceration and subdural hematoma. Cat Scan of head/brain without contrast on 8/06/2024 at 5:12 a.m. indicates a small focal left parietal subdural hemorrhage which is acute in appearance. Assessment and plan indicate resident to be a DNR, has a small subdural present over the left parietal convexity, finding requires no surgical intervention and per family, even if surgery necessary this would not be desired for her. Recommendations: maintain normotension; max Systolic blood pressure 150 mm/hg; avoid all antiplatelets and anticoagulants for 10 days; Keppra regimen for 6 days - may stop at that point if no seizure activity, if seizures occur continue x 90 days and referral to neurology for formal follow up; DVT prophylaxis; neuro-checks as ordered; and no further report CT scans warranted in the absence of precipitous neurological decline. No acute neurological issues. Record review of TULIP intake for Resident #1 indicated information date received on 08/06/2024 at 10:24 a.m., read the allegation of neglect (fall) occurred on 08/05/2024 at 5:00 p.m. and resident was sent to local hospital for treatment and evaluation, and it was later determined at 08/05/2024 at 8:30 p.m. (14 hours prior) the fall had caused serious bodily injury (brain bleed) and was sent to a [name of city] hospital for treatment. Caller information indicates the reporter of the allegation was the Abuse Coordinator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 08/07/2024 at 10:15 a.m., Resident #1 was lying in bed, alert but pleasantly confused, unable to answer questions appropriately regarding the fall incident on 08/05/2024. Resident #1 had a laceration approx. 2.5 cm long to her left forehead with suture intact. Forehead laceration and surrounding tissue with bruising and discoloration noted. During an interview on 08/07/2024 at 1:45 p.m., RN B said she was the charge nurse for Hall 3 (Resident #1's hall) on 08/05/2024 evening shift. She said around 4:45 p.m. that evening CNA A had brought Resident #1 from the dining area to take her to the restroom as requested, she frequently request to go to bathroom. During transport CNA A was instructed to assist CNA C to get another resident up to chair for supper. RN B said Resident #1 was in the hallway and was informed CNA A would be right back to help her. CNA A went to room next door to assist CNA C to get another resident out of bed for supper. RN B said Resident #1 was in the hallway close to her room, CNA A came out of other residents' room (within 5 minutes) and explained she was getting supplies to help Resident #1 to the bathroom. RN B said she continued passing medications and within a few minutes she was summoned by CNA C Resident #1 was found on the floor. RN B said she and CNA A had seen Resident #1 sitting in her wheelchair outside of her room just minutes prior to the incident. RN B said when she entered Resident #1's room LVN E, CNA A and CNA C were in the room, Resident #1 was lying on her left side with bleeding noted from laceration on left forehead. RN B said she immediately applied pressure to the forehead laceration in attempts to stop the bleeding. RN B said Resident #1 was upset and swinging her arms to prevent pressure to be applied to forehead laceration, resident repeated said it hurts, it hurts. RN B said she was finally able to stop bleeding and applied pressure dressing to forehead laceration but Resident #1 would not allow staff to obtain vital signs during the incident. RN B said while she was assessing Resident #1 LVN E contacted EMS, MD, and RP. RN B said staff stayed with her and attempted to calm resident by holding her hand and talking to her, she calmed down once the EMS arrived (within 10-15 minutes of incident) and Resident #1 was applied pressure to her forehead laceration at time of transport. RN B said Resident #1 was moving all extremities and no other acute injuries observed during the initial assessment after the fall/incident. RN B said Resident #1 had a history of falls and she was a resident that was watched/monitored closely to prevent falls. RN B said Resident #1 was mobile in her wheelchair and she moves around the facility freely. She said she stays at the nurses' station or CNA's station and the lobby area so staff can keep an eye on her. Resident #1 has a bed and chair alarm to detect excessive movement and room was close to nurses' station to easily detect, observe or hear resident. RN B said Resident #1 required assistance from 1 staff member to transfer to wheelchair but was independent with mobility once in wheelchair. RN B said she notified the DON (management on call) regarding the fall incident shortly after it occurred on 08/05/2024 and then later updated the DON on 08/05/2024 at 8:30 p.m. when information was received resident was being transferred to another hospital due to fall had caused a subdural hematoma/hemorrhage. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 2:15 p.m., LVN E said she was the charge nurse for the other halls on 08/05/2024 evening shift. LVN E said she was in the dining room passing trays for supper time and CNA C came into dining are requesting assistance because Resident #1 was found on the floor, and she was bleeding. LVN E said she immediately went to Resident #1's room, found Resident #1 lying on the floor on her left side at end of her bed. LVN E said she saw blood under Resident #1's head but was unable to determine amount of blood because the way she was laying. LVN E said began assessing Resident #1 and requested CNA staff to get towels and supplies to help with assessment and to control bleeding. LVN E said RN B entered room within one minute and applied pressure to laceration on the left forehead. LVN E said Resident #1's body alignment appeared straight, knees bent, moving both arms not wanting staff to touch her, and moved both legs. LVN E said she and RN B repositioned head to attempt to assess laceration to left forehead, found forehead laceration deep and would require closure. LVN E said she went to nurses' station and called EMS, RP, MD, hospice, local ER and provided report. LVN E said Resident #1 was at her baseline cognitively of alert and oriented x 1. LVN E said Resident #1 was not her assigned resident, but she was aware Resident #1 had a history of falls and staff monitor her closely to prevent falls. LVN E said interventions for fall prevention include lower bed, fall mats, bed/chair alarms, frequent monitoring, and keep certain residents in site at much as possible. During an interview on 08/07/2024 at 2:38 p.m., CNA A said on 08/05/2024 Resident #1 was up in wheelchair when she came on shift and had been assisted to the bathroom prior to transporting her by wheelchair to the dining room for supper, around 4:30 p.m. Resident #1 requested to go to the bathroom again, she transported Resident #1 back to the hallway by her room. CNA A said she was told by RN B the CN to go help get another resident up for dinner, and CNA A told Resident #1 she would return shortly to help her to the restroom. CNA A said she went to next room and assisted CNA C to get another resident up to chair for dinner as directed by CN. CNA A said after exiting the other resident's room (5-7 minutes later) came by dining area checked on her other assigned residents and started down hall 3 to get supplies, Resident #1 was observed inside her room and instructed her she was getting supplies to take her to the restroom. CNA A said she was at the nearby cart/ben getting supplies to assist Resident #1 when she heard a noise and faint ouch, and she immediately went to Resident #1's room found resident lying on her left side with glasses on and bleeding from head. CNA A said she hollered for help and CNA C responded and summoned help from CN. CNA A said both CN's (RN B and LVN E) responded immediately. CNA A said Resident #1 was alert and saying her head hurt, she was swinging her arms and not wanting CN to apply pressure to laceration on forehead. CNA A said they were trying to calm her down by talking to her and holding her hands while CN completed assessment. CNA A said she did not feel she was trying to go to the restroom because she was found in her room beside her bed not in the restroom area. CNA A said Resident #1 uses a bed and chair alarm but does not recall if the chair alarm sounded. CNA A said chair and bed alarms were checked (turned on and off) when residents were transferred into chair/bed. CNA A said Resident #1 had a history of falls, so she was monitored closely by staff, and measures put in place to prevent falls (lower bed, fall mats, bed and chair alarms and frequent monitoring). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676000	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 3:45 p.m., CNA C said CNA A was coming down the hall with Resident #1 and CN instructed her to help her get the other resident up for supper. CNA A explained to Resident #1 she would help her to restroom as soon as she completed the assigned task. CNA C said CNA A helped her get the other resident up to the chair for supper and exited the room. CNA C said the task of getting resident up did not take more than 5 minutes and CNA A exited the room. CNA C said she completed assisting the resident and exited the room, she heard CNA A hollering for help. CNA C said she entered Resident #1's room and saw CNA A kneeled beside Resident #1, resident on floor with blood under head, went to dining room and got CN (LVN E) and she immediately went to Resident #1's room and instructed her to get towels and supplies and bring to room and find other CN (RN B). CNA C said she quickly collected requested supplies and took them to Resident #1's room and notified CN (RN B) of the incident. CNA C said CN (RN B) was holding pressure to laceration on head trying to stop the bleeding and CNAs were trying to calm the resident my talking to her and holding her hand. CNA C said CN (LVN E) left the room once assessment completed but CN (RN B) stayed with Resident until EMS arrived. CNA C said Resident did not say how she fell just kept saying her head hurt. CNA C said she left the room when CN gave her permission to leave. CNA C said EMS arrived with 10-15 minutes of the incident and transported her out to ER. CNA C said Resident #1 had a history of falls and she was monitored closed to prevent falls, she would sit at the nurses' station or CNA station, stays in lobby/common area so staff at nurses' station could keep her in eyesight. CNA C said Resident #1 was independent with wheelchair mobility but required one person assists for transfers and most care. CNA C said Resident #1 used a bed and chair alarm but does not recall if the chair alarm sounded. CNA C said chair and bed alarms were checked (turned on and off) when residents were transferred into chair/bed. During an interview on 08/07/2024 at 4:15 p.m., the DON said he learned about the incident with Resident #1 on 08/06/2024 when he awoke to read a text message from RN B regarding Resident #1 had a fall on 08/05/2024 at 6:00 p.m. and another text message on 08/05/2024 at 8:30 p.m. Resident #1 has sustained a subdural hematoma/hemorrhage from fall and was being transferred to a higher left of care hospital. DON said he was already asleep, and the text messages did not wake him up. DON said the facility has changed the protocol and the facility staff must call the management on call with any incidents no text messaging. DON said he should have notified the abuse coordinator or administrator immediately once he received the text or information regarding the severity of the injury from the fall. DON said due to the severity of the injury sustained with the fall the injury/allegation should have been reported to the state immediately or within 2 hours once facility notified of the severity of the injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676000	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health Care LLP	1620 US 59 N Livingston, TX 77351

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/07/2024 at 5:15 p.m., the Abuse Coordinator said she was not made aware of Resident #1's fall with serious bodily injury until the next morning 08/06/2024 when she was reading her incident report emails. The Abuse Coordinator said the CN (RN B) notified the DON (manager on call) via text message of the incident and later the severity of the injury and he did not forward the information until 08/06/2024. The Abuse Coordinator said she completed the report to the state as soon as she was made aware of the incident and the severity of the injury on 8/6/2024 at 10:24 a.m. The Abuse Coordinator said the DON should have immediately notified her once he was aware of the incident and the severity of the injury, and she would have reported it to the state immediately or within 2 hours as required. The Abuse Coordinator was aware of reportable times for incident types of abuse (with or without serious bodily injury) or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury must be reported immediately but no later than two hours after the incident occurs or is suspected. The Abuse Coordinator said she uses THHSC long-term care regulatory provider letter PL 19-17 for guidance related to reporting abuse and neglect. The Abuse Coordinator said that the facility Abuse and Neglect policy did not identify and describe required reporting timeframes for incidents involving abuse (with or without serious bodily injury) or neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, that result in serious bodily injury to be reported immediately but no later than 2 hours after the incident occurs or suspected to THHSC. The Abuse Coordinator said she uses THHSC long-term care regulatory provider letter PL 19-17 for guidance related to reporting abuse and neglect. During an interview on 08/07/2024 at 6:15 p.m., the Administrator said the expectations was for the facility staff to report all suspicions or allegations of abuse or neglect with serious bodily injury immediately to her and/or the abuse coordinator. She said the timeframe for reporting allegations of neglect with serious bodily injury to the state agency was to report within 2 hours of the allegation. The administrator said she or the designee should have reported allegations of abuse to the state agency within 2 hours of the allegation. Record review of the facility's Abuse and Neglect and misappropriation policy dated 06/13/2023 indicated . B. Reporting 1. If an employee witnesses, is notified of or, suspects abuse, the following mandatory steps are taken a. ensure immediate safety of victim b. seek appropriate medical evaluation and treatment c. in cases of sexual and physical abuse protect all potential evidence: secure scene; sexual assault abuse victim must undergo medico-legal examination prior to bathing or changing clothes; identify witnesses; and secure evidence in locked areas. d. notify immediate supervisor, Administrator, Director of Nursing, and abuse coordinator e. notify physician f. report to law enforcement and adult Protective Services as mandated under Texas State law g. notify guardian, legal power of attorney or designated next of kin. h. complete incident report. The facility must ensure that all alleged violations involving mistreatment neglect or abuse including injuries of unknown source and misappropriation of resident property are reported immediately submitted to TDHS, [NAME] TX [PHONE NUMBER].