STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676003	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azle Manor Health Care and Rehabilitation	721 Dunaway LN Azle, TX 76020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 48177 Based on observation, interview, and record review, the facility failed to ensure the resident's environment remained as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 12 residents reviewed for accidents. The facility failed to provide Resident #1 with ADL care in a safe manner, allowing Resident #1 to fall off her bed on 5-21-2024 between 4:00-4:30 PM, while her shirt was being changed by a staff member. An immediate Jeopardy (IJ) situation was identified on 6-5-2024 at 5:41 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of its corrective systems. This failure resulted in actual harm due to facility staff not following proper transfer protocol which caused Resident #1 to fall and incur a fracture, placing residents who required two-person transfers at risk of serious injury, harm, impairment, or death. Findings Included: Record review of Resident #1's Face Sheet dated 6-4-2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of Alzheimer's Disease with late onset, and secondary diagnosis of Dementia, Cerebral Infarction (Stroke), and Need for Assistance with Personal Care. Record review of Resident #1's Comprehensive MDS Assessment, dated 3-25-2024, revealed Resident #1 had a BIMS Score of 11 indicating moderate cognitive impairment. Section GG revealed Resident #1 was Dependent (Helper does all 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 upper body/lower body dressing, bathing, and Chair-to-bed transfers. Because of Resident #1's medical conditions or safety concerns, Resident #1 was coded for there to be no attempt made by staff to move Resident #1 from Lying to sitting on side of bed. Resident #1 had a diagnosis of stroke, brain and spinal cord dysfunction, amputation, hip and knee replacement, fractures, and other multiple traumas. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident#1's Care Plan, dated 4-5-2024, indicated Resident #1 had an ADL self-care performance deficit and required maximum assistance for lying in bed to sitting on the side of the bed by staff. Resident #1 also had a right hip fracture which placed Resident #1 at risk for pain, informing staff to be alert for nonverbal pain cues (changes in vital signs, emotions, and behavior). Listen to reports of family members regarding my pain. The right hip fracture put Resident #1 at risk for falls and impaired physical mobility. The care plan stated for staff to follow facility fall protocol. Resident #1 had a fall on 5-4-2023 causing a right hip fracture. Resident #1's Care Plan reflected Right hip fracture status post reduction percutaneous pinning placing at risk for pain, limited ROM, mobility, peripheral neurovascular dysfunction, impaired gas exchange, impaired physical mobility, impaired skin integrity, infection, Knowledge deficit, further injury, and falls Impaired physical mobility evidenced by: Inability to move purposefully within the physical environment, imposed restrictions. On 6-4-2024, at 5:30 PM, record review of Resident #1's MAR, revealed LVN A gave Resident #1 one 50-milligram tablet of Tramadol, for pain, on 5-21-2024 at 4:16 PM. Record review of Resident #1's Nursing Notes dated 5-21-2024 revealed the following: 7:00 PM, Nurse Note Text: N/O received from MD for STAT L knee X-Ray. Dx: Pain & to change PRN Tramadol to Tramadol 50mg TID. MAR updated & XR ordered. 10:23 PM - Nursing Note Text: This writer informed by staff that resident fell in her room on her knee during transfer. Resident crying for pain on left leg. Upon MD assessment, resident given additional pain medication and new order for STAT X-ray. Pain medication administered and MD order obtained. BP 152/72 P 79 SPO2 99% RR 20 Temp. 97.7 DON, MD and POA notified. 10:40 PM - Nurse Note Text: XR results positive for Comminuted fracture of the left distal femur just above the femoral condyles. MD notified. Order given to send resident out for evaluation & treatment. family member #1, , notified. When informed that family member #2, , would be notified next, family member #1, stated no that she would like to call herself. Resident was sent to an ER via EMS. 11:00 PM - Nurse Note Text: Report called into an [sic] ER. Resident not received. Resident was transferred to THR FW. Report called in & family member #2 & family member #1, notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA A, on 6-4-2024 at 2:00 PM, it was revealed CNA A was a CNA in training but had completed the in-house CNA training program. CNA A stated she had not yet taken her exam to be a certified CNA. CNA A worked the 2 PM-10 pm shift and had worked at the facility for approximately 6 weeks. CNA A stated on 5-21-2024, around dinner time, at approximately 4:30pm, she went into Resident #1's room, by herself, to prepare her for a Mechanical lift Transfer. CNA A stated Resident #1 needed her shirt changed and sat Resident #1 up from a lying position to a sitting position, on the side of Resident #1's bed facing CNA A. CNA A stated Resident #1 started to slip off the bed and she was not strong enough to hold Resident #1. As a result, Resident #1 fell off the bed onto the floor. CNA A said Resident #1 made an ouch noise as her left knee was bent underneath her, sitting on her left foot. CNA A stated she ran to the doorway, saw CMA B, and called for her to help her. CNA A and CMA B lifted Resident #1 off the floor back onto Resident #1's bed by hand. Once Resident #1 was back on her bed, CMA B told CNA A that Resident #1's left leg looked swollen while Resident #1 was crying. CNA A stated at that point, CMA B told CMA A to go find a nurse and tell the nurse that Resident #1 needed something for pain. CMA B then left the room of Resident #1 and goes back doing her job duties in the hallway. CNA A said she left the room of Resident #1, found LVN A, on another hall, told LVN A that Resident #1 needed some pain medication. CNA A stated that she did not tell LVN A that Resident #1 had a fall but only about needing a pain pill. CNA A stated that she assumed CMA B was going to tell a nurse about Resident #1 falling. CNA A stated after she told LVN A that Resident #1 needed a pain pill, CNA A went back to doing other duties that she was assigned and left Resident #1 in her bedroom alone. CNA A did not know how long it took for Resident #1 to get a pain pill. CNA A stated that somewhere between 5:30 PM to 6:00 PM, she was working in the dining room, assisting residents with feeding, when she saw the MD. CNA A said she told MD about Resident #1 falling. CNA A stated MD rolled Resident #1 out of the dining room in her wheelchair. CNA A stated that the next day, 5-22-2024, the DON called her into her office and stated that she should not have sat Resident #1 up on the side of her bed but should have kept her in a lying position and changed her shirt. The DON further told CNA A, that she and CMA B should not have put Resident #1 back onto her bed without a nurse being present. The DON told CNA A she should not have assumed CMA B had told a nurse about Resident #1 falling, should have already had the Mechanical lift in the room because Resident #1 is a Mechanical lift, and should have used the Mechanical lift to move Resident #1, before trying to sit Resident #1 up. CNA A stated she has been using Mechanical lifts for a month. In an interview with CMA B, on 6-4-2024, at 3:30 PM, it was revealed that CMA B had worked at the facility for two years, worked the evening shift from 2 PM-10 PM, and worked halls 200-300. CMA B stated she was working on 5-21-2024, and ordering medications around 4:30 PM, when she heard her name being called by CNA A to come help her with Resident #1. CMA B stated she walked into Resident #1's room, saw Resident #1 sitting on the floor, and assisted CNA A in helping Resident #1 back onto her bed. CMA B stated she then retrieved the Mechanical lift, brought it into Resident #1's room, moved Resident #1, with the help of CNA A, from the bed to her wheelchair. CMA B stated Resident #1 was crying and in pain. CMA B stated she assumed Resident #1 was in pain from a past fall she had at the facility -breaking her hip. At that time, CMA B wheeled Resident #1 in her wheelchair to the nurse's station to get pain medication. CMA B stated she left Resident #1 at the nurse's station with LVN A to get pain medicine while CMA B went back to ordering medications. CMA B did not have a time frame to give but said someone wheeled Resident #1 into the dining room to eat supper. CMA B said, at some point in time, CNA A saw the MD, in the dining room, and told MD that Resident #1 had fallen. CMA B said somewhere around 5:30-5:40 PM, she and MDS Coordinator wheeled Resident #1, in her wheelchair, back to her room and put her in her bed so the MD could examine her. CMA B stated that around 6:20 PM, she gave Resident #1 her regular medication pass. CMA B stated after that, she had no more interaction with Resident #1 for the day. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON, on 6-4-2024, at 3:45 PM, she stated that CMA B was assigned to mentor CNA A. The DON said that the problem with the fall incident with Resident #1 was the aides moved Resident #1 without an assessment from a nurse. The DON stated that CMA B and CNA A were both written up for the incident. In an observation/interview with Resident #1, on 6-4-2024, at 4:30 PM, Resident #1 was observed lying in bed wearing an oxygen cannula. Resident #1 was speaking very softly and was very hard to hear when she said, on the day she fell , one person was trying to get her ready, and she slid off her bed. Resident #1 stated she was in a lot of pain but could not put a number rating on the pain. Resident #1 stated it was a long time before she received pain medication for the fall. In an interview, on 6-4-2024, at 5:00 PM, LVN A stated she had been working at the facility full-time since January 2024 and worked the evening shift from 2:00 PM - 10:00 PM. LVN A said she worked various halls according to what the facility needed. LVN A said on 5-21-2024 at approximately 4:45 PM, just before dinner, a trainee CNA (CNA A) came to her to ask for pain medication for Resident #1. LVN A said she told CNA A, it does not work that way, I will come and look at Resident #1. LVN A said she was working on a different hall, than the one Resident #1 was on, when CNA A told her about Resident #1 needing pain medicine. LVN A would not state the time it took her to come to Resident #1's hall to check on her. LVN A said she pushed her nursing cart to where Resident #1 was sitting in her wheelchair. LVN A stated that when she found Resident #1, she was sitting by herself, close to the nurse's station. LVN A said she asked Resident #1 what was wrong. Resident #1 responded she was in pain. LVN A stated she then gave Resident #1 a pain pill. LVN A said sometime before 6:00 PM, she called for someone to take Resident #1 to the dining room to get assistance with eating. LVN A said later (she did not state the time) she witnessed the MD talking to Resident #1 and escorted Resident #1 back to her room. LVN A stated no one told her that Resident #1 had fallen. LVN A stated, during the time of her employment at the facility, she always witnessed a trainee CNA with a fully trained staff in situations where Resident #1 was getting prepped to transfer. LVN A said it was unusual for a trainee CNA to be doing such things by herself. LVN A said at some point, the MD took over doing an assessment on Resident #1 and ordered x-rays. LVN A said dinner started at 5:30 PM. In an interview, on 6-5-2024, at 11:45 AM, CNA C (in training), stated she had worked at the facility since May 13, 2024, and worked on the morning shift from 6:00 AM - 2:00 AM. CNA C stated she finished the classroom training program for CNAs yesterday (06-04-2024). CNA C said she was allowed to watch licensed staff complete a task and then she could complete the task with licensed supervision but not alone. CNA C said if a licensed CNA or nurse instructed her to do something, then she can do it alone. CNA C said Mechanical lift patients cannot be sat up in bed whether one was licensed or not. This was part of what the in-house training program teaches. If they were a fall risk and don't have the strength to hold themselves up, they should either roll them on the bed or use a Mechanical lift to put them in the wheelchair to change their shirt. CNA C stated the fall protocol for the facility was to get a nurse immediately when a resident fell and to not touch or move them. CNA C stated when she started her in-house training, at the facility, there were 7 CNA trainees. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview, on 6-5-2024, at 12:20 PM, with the MD, it was disclosed the MD was at the facility on 5-21-2024 during dinner time. The MD refused to give a more specific time frame. The MD said she was seeing patients during dinner time, with the MDS Coordinator, when Resident #1's [Family Member #2] brought Resident #1 to a TV room, then came to the nurse's station, saying Resident #1 was in pain. MD said LVN A told her she had already given Resident #1 something for pain. The MD said she went to the TV room and asked Resident #1 how she was feeling. Resident #1 responded saying she was in pain. The MD said she then brought Resident #1 back to her room, assessed her, and saw that her left knee was swollen. The MD said she then ordered a stat x-ray and gave Resident #1 Norco pain medicine. In an interview, on 6-5-2024, at 1:00 PM, the Training Coordinator said CNA A started her classroom training on 4-15-2024 and completed it on 5-3-2024. The Training Coordinator said once CNA A finished her classroom training, she was on her own. In an interview on 6-5-2024, at 1:15 PM, the DON said trainees were hired at first as hospitality aides. The DON said CNA A had finished her classroom training one day before the incident on 5-20-2024. The DON said the facility did not train CNAs to sit residents up on a bed before a Mechanical lift was used. The DON said the facility did not have a policy against sitting Mechanical lift Residents up in bed. In an interview, on 6-5-2024, at 3:00 PM, [Family Member #1] revealed she received a phone call on 5-21-2024, at 5:00 PM, from one of the facility's physical therapists, and told her that Resident #1, was sitting in a hallway crying and that she should have come to the facility and checked on her. Resident #1's [Family Member #1] then called Resident #1's [Family Member #2] and told her what the PT told her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview, on 6-5-2024, at 3:24 PM, [Family Member #2] revealed she had received a phone call from [Family Member #1] informing her that Resident #1 was at the facility crying sitting in a hallway and that she needed to check on Resident #1. Resident #1's [Family Member #2] said she arrived at the facility around 5:40 PM and found Resident #1 in the dining room sitting at a dining table in her wheelchair. Resident #1's [Family Member #2] said Resident #1 told her she was in pain and her left leg hurt. Resident #1 kept saying this repeatedly to Resident #1's [Family Member #2]. As a result, Resident #1's [Family Member #2] started to wheel Resident #1, out of the dining room, to the nurse's station, when CNA A approached Resident #1's [Family Member #2] and told her that CNA A, earlier in the evening, was attempting to change Resident #1's shirt while she was seated on her bed, and Resident #1 fell . CNA A then told Resident #1's [Family Member #2] that Resident #1 was okay as she was eating her food. Resident #1's [Family Member #2] then wheeled Resident #1 to the nurse's station and asked the nurses about Resident #1 falling earlier in the day. Resident #1's [Family Member #2] said the nurses did not know Resident #1 had fallen earlier in the evening. Resident #1's [Family Member #2] said the MD was also at the nurse's station and overheard this conversation. Resident #1's [Family Member #2] said LVN A informed her that Resident #1 had received a Tramadol pill and she was fine. Resident #1's [Family Member #2] then told LVN A that Resident #1 was not fine and was crying in pain. Resident #1's [Family Member #2] then said the MD took Resident #1 and her family member to the dining room, where CNA A told the MD that Resident #1 had fallen earlier in the evening. The MD, Resident #1's, and her family member then went to the TV room together, where the MD examined Resident #1. Resident #1's [Family Member #2] said then other staff wheeled Resident #1 back into her room where staff put her back in bed, at which time she screamed in pain. Resident #1's [Family Member #2] said she had never heard Resident #1 scream like that in pain in her entire life. Resident #1's [Family Member #2] said that on a pain scale of 0-10, Resident #1 was past a 10 on 5-21-2024. In an interview, on 6-5-2024 at 4:40 PM, the MDS Coordinator disclosed she assisted Resident #1 back into her bed with CMA B for the MD to finish assessing Resident #1. The MDS Coordinator stated Resident #1 was crying in pain, so she administered Norco to Resident #1. MDS Coordinator did not give a time frame as to when this occurred. In an interview on 6-5-2024, at 4:45 PM, CMA B confirmed that she and the MDS Coordinator transferred Resident #1 back into her bed after 6:00 PM and Resident #1 was crying in pain. Record review, on 6-5-2024, at 5:20 PM, of the facility's Fall Prevention Policy, dated 3-12-2022, reflected: Policy:w It is the policy of this facility to ensure that risks and factors contributing to falls are mitigated as able. Policy Explanation and Compliance Guidelines: 1 - Upon admission and with noted risks such as prior a prior fall, resident will be assessed. If a fall was present, an incident report will be completed. 2 - Physician and responsible party will be notified of fall immediately. 3 - If a fall was unwitnessed or the resident was unable to communicate if head injury occurred, neuros will be initiated, and resident will be monitored for two subsequent shifts. Resident may be sent to the hospital based on nursing assessment and MD order. 4 - New fall risk assessment will be completed with contributing factors identified such as new medications, appropriate footwear, lighting and other contributing factors. Record review, on 6-5-2024, at 5:25 PM, of the facility's Fall Risk Assessment Policy, dated 3-12-2022, reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy: It is the policy of this facility to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents . (.) 3 - An At Risk for Fall care plan will be completed for each resident to address each item identified on the risk assessment and will be updated accordingly. On 6-5-2024, at 5:41 PM, the Administrator was notified that an Immediate Jeopardy had been identified and exited on 5-21-2024, and a copy of the IJ template was provided to the Administrator regarding Accident/Hazards. The following POR was accepted on 6-6-2024 at 3:14 PM: F689 - Failure to provide resident adequate supervision and assistance devices to prevent accidents. F689 - Accidents/Hazards Azle Manor Plan of Removal Azle Manor submits the following Plan of Removal for F689 related to the alleged action of accidents/hazards by not following proper protocol in the capacity of a trainee, which caused a resident to fall and incur a fracture. By submitting this plan of removal Azle Manor does not admit to the accuracy of the alleged deficient practice. What corrective actions have been implemented for the identified residents? On 5/22/24 residents identified as requiring mechanical lift have been assessed for appropriate transfer technique. Mechanical lift Audit was completed, and care plans updated. One-on-one competency training on Post-Fall Protocol and mechanical lift training was completed by the DON with staff members CNA and CMA-A on 5/22/24. o Competency consists of Mechanical Lift Pre-Operations Checks and Mechanical Lift Operations. o Fall Prevention and Post-Fall Protocol Fall Prevention Response to falls-notification of nurse Intrinsic/Extrinsic Factors increasing risk Use of correct transfer type/assistive devices (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Walkway-room hazards Keeping items within reach Disciplinary action has been completed with staff members CNA and CMA-A for not following the proper protocol on 5/22/24. How were other residents at risk to be affected by this deficient practice identified? All residents identified as requiring mechanical lift have been identified as being at risk to be affected by this alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? CNA Student(s), CNA(s), Medication Aides, and Licensed Nurses have completed Total Mechanical Lift Training was completed on 5/29/2024 by the Director of Rehab/Therapy. Staff completed in-service training were cleared to work with residents requiring mechanical lifts. Using active staff roster, all clinical/direct-care staff attended the in-service training prior to working with residents requiring mechanical lift. How will the system be monitored to ensure compliance? o All new residents will be reviewed upon admission and change of condition to identify those that require total mechanical lift by Therapy (OT/PT) screening services. o DON will verify all CNA Students are properly trained and have completed competencies related to mechanical lift, post-fall policy and procedure. o DON, ADON, or nurse manager will round in facility to ensure appropriate use of mechanical lift for identified residents. o Mechanical lift rounds began 5/22/24 and will be completed three times weekly x 14 days; then weekly for three months and as needed. o Any discrepancies noted throughout monitoring period will immediately be reviewed by Quality Assurance Team. Of Note The CNA in-training term used does not correctly identify the staff, Student CNA. Student CNA has met all the requirements for OBRA nurse aide training regulations per the Nurse Aide Training and Competency Evaluation Program (NATCEP) set forth in the Texas Curriculum for Nurse Aides in Long-Term Care Facilities. The OBRA nurse aide training regulations include: o Placed on the Nurse Aide Registry o The first 16 hours of training must be completed prior to any direct contact with a resident. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on observation, interview, and record review the facility failed to ensure that adequate pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 (Resident #1) of 12 residents reviewed for pain management. The facility failed to ensure Resident #1 was properly assessed, monitored, and received effective pain management after Resident #1 fell on [DATE] at approximately 4:30 PM and sustained a comminuted fracture of the left distal femur just above the femoral condyles and was not sent to the hospital for treatment for 6.5 hours at approximately 11:00 PM. The nurse was not notified for 1 to 1.5 hours of the fall until Resident #1's family member intervened and notified the nurses of Resident #1's pain. An immediate Jeopardy (IJ) situation was identified on 6-5-2024 at 5:41 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of its corrective systems. These failures placed residents at risk of experiencing significant pain and discomfort. Findings Included: Record review of Resident #1's Face Sheet dated 6-4-2024, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had a primary diagnosis of Alzheimer's Disease with late onset, and secondary diagnosis of Dementia, Cerebral Infarction (Stroke), and Need for Assistance with Personal Care. Record review of Resident #1's Comprehensive MDS Assessment, dated 3-25-2024, revealed Resident #1 had a BIMS Score of 11 indicating moderate cognitive impairment. The Functional abilities and goals section revealed Resident #1 was Dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers were required for the resident to complete the activity) for upper body/lower body dressing, bathing, and Chair-to-bed transfers. Because of Resident #1's medical conditions or safety concerns, Resident #1 was coded for there to be no attempt made by staff to move Resident #1 from Lying to sitting on side of bed. Resident #1 had a diagnosis of stroke, brain and spinal cord dysfunction, amputation, hip and knee replacement, fractures, and other multiple traumas. Record review of Resident #1's doctor orders revealed an order for Norco Oral Tablet 325 MG to being on 5-28-2024 to be given for pain every 6 hours as needed for pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident#1's Care Plan, dated 4-5-2024, indicated Resident #1 had an ADL self-care performance deficit and required maximum assistance for lying in bed to sitting on the side of the bed by staff. Resident #1 also had a right hip fracture which placed Resident #1 at risk for pain, informing staff to be alert for nonverbal pain cues (changes in vital signs, emotions, and behavior). Listen to reports of family members regarding my pain. The right hip fracture put Resident #1 at risk for falls and impaired physical mobility. The care plan stated for staff to follow facility fall protocol. Resident #1 had a fall on 5-4-2023 causing a right hip fracture. Resident #1's Care Plan reflected Right hip fracture status post reduction percutaneous pinning placing at risk for pain, limited ROM, mobility, peripheral neurovascular dysfunction, impaired gas exchange, impaired physical mobility, impaired skin integrity, infection, Knowledge deficit, further injury, and falls Impaired physical mobility evidenced by: Inability to move purposefully within the physical environment, imposed restrictions. record review of the MAR for Resident #1, on 6-5-2024, at 5:00 PM, revealed Resident #1 received Norco on 5-21-2024 at 6:20 PM. Record review of Resident #1's Nursing Notes dated 5-21-2024 revealed the following: 7:00 PM, Nurse Note Text: N/O received from MD for STAT L knee X-Ray. Dx: Pain & to change PRN Tramadol to Tramadol 50mg TID. MAR updated & XR ordered. 10:23 PM - Nursing Note Text: This writer informed by staff that resident fell in her room on her knee during transfer. Resident crying for pain on left leg. Upon MD assessment, resident given additional pain medication and new order for STAT X-ray. Pain medication administered and MD order obtained. BP 152/72 P 79 SPO2 99% RR 20 Temp. 97.7 DON, MD and POA notified. 10:40 PM - Nurse Note Text: XR results positive for Comminuted fracture of the left distal femur just above the femoral condyles. MD notified. Order given to send resident out for evaluation & treatment. [Family member #1], notified. When informed that [family member #2], would be notified next [family member #2], stated no that she would like to call herself. Resident was sent to emergency room via EMS. 11:00 PM - Nurse Note Text: Report called into the emergency room . Resident not received. Resident was transferred to the emergency room . Report called in & RP, [family member #2] & [family member #1], notified. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA A, on 6-4-2024 at 2:00 PM, it was revealed CNA A was a CNA in training but had completed the in-house CNA training program. CNA A stated she had not yet taken her exam to be a certified CNA . CNA A stated on 5-21-2024, around dinner time, at approximately 4:30pm, she went into Resident #1's room, by herself, to prepare her for a Mechanical lift Transfer. CNA A stated Resident #1 needed her shirt changed and sat Resident #1 up from a lying position to a sitting position, on the side of Resident #1's bed facing CNA A. CNA A stated Resident #1 started to slip off the bed and she was not strong enough to hold Resident #1. As a result, Resident #1 fell off the bed onto the floor. CNA A said Resident #1 made an ouch noise as her left knee was bent underneath her, sitting on her left foot. CNA A stated she ran to the doorway, saw CMA B, and called for her to help her. CNA A and CMA B lifted Resident #1 off the floor back onto Resident #1's bed by hand. Once Resident #1 was back on her bed, CMA B told CNA A that Resident #1's left leg looked swollen while Resident #1 was crying. CNA A stated at that point, CMA B told CMA A to go find a nurse and tell the nurse that Resident #1 needed something for pain. CMA B then left the room of Resident #1 and goes back doing her job duties in the hallway. CNA A said she left the room of Resident #1, found LVN A, on another hall, told LVN A that Resident #1 needed some pain medication. CNA A stated that she did not tell LVN A that Resident #1 had a fall but only about needing a pain pill. CNA A stated that she assumed CMA B was going to tell a nurse about Resident #1 falling. CNA A stated after she told LVN A that Resident #1 needed a pain pill, CNA A went back to doing other duties that she was assigned and left Resident #1 in her bedroom alone. CNA A did not know how long it took for Resident #1 to get a pain pill. CNA A stated that somewhere between 5:30 PM to 6:00 PM, she was working in the dining room, assisting residents with feeding, when she saw the MD. CNA A said she told MD about Resident #1 falling. CNA A stated MD rolled Resident #1 out of the dining room in her wheelchair. CNA A stated that the next day, 5-22-2024, the DON called her into her office and stated she and CMA B should not have put Resident #1 back onto her bed without a nurse being present. In an interview with CMA B, on 6-4-2024, at 3:30 PM, it was revealed that CMA B assisted CNA A in helping Resident #1 back onto her bed after she fell on the floor during care. CMA B stated Resident #1 was crying and in pain. CMA B stated she assumed Resident #1 was in pain from a past fall she had at the facility -breaking her hip. At that time, CMA B wheeled Resident #1 in her wheelchair to the nurse's station to get pain medication. CMA B stated she left Resident #1 at the nurse's station with LVN A to get pain medicine while CMA B went back to ordering medications. CMA B did not have a time frame to give but said someone wheeled Resident #1 into the dining room to eat supper. CMA B said, at some point in time, CNA A saw the MD, in the dining room, and told the MD that Resident #1 had fallen. CMA B said somewhere around 5:30-5:40 PM, she and MDS Coordinator wheeled Resident #1, in her wheelchair, back to her room, and put her in her bed so the MD could examine her. CMA B stated that around 6:20 PM, she gave Resident #1 her regular medication pass. CMA B stated after that, she had no more interaction with Resident #1 for the day. In an interview with the DON, on 6-4-2024, at 3:45 PM, it was stated that CMA B was assigned to mentor CNA A. The DON stated that the problem with the fall incident with Resident #1 was the aides moved Resident #1 without an assessment from a nurse. The DON stated that CMA B and CNA A were both written up for the incident. In an observation/interview with Resident #1, on 6-4-2024, at 4:30 PM, Resident #1 was observed lying in bed with a oxygen cannula. Resident #1 was speaking very softly and was very hard to hear when she said, on the day she fell , one person was trying to get her ready, and she slid off her bed. Resident #1 stated she was in a lot of pain but could not put a number rating on the pain. Resident #1 stated it was a long time before she received pain medication for the fall. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview, on 6-4-2024, at 5:00 PM, LVN A stated she had been working at the facility full-time since January 2024 and worked the evening shift from 2:00 PM - 10:00 PM. LVN A said she worked various halls according to what the facility needed. LVN A said on 5-21-2024 at approximately 4:45 PM, just before dinner, a trainee CNA (CNA A) came to her to ask for pain medication for Resident #1. LVN A said she told CNA A, it does not work that way, I will come and look at Resident #1. LVN A said she was working on a different hall, than the one Resident #1 was on, when CNA A told her about Resident #1 needing pain medicine. LVN A would not state the time it took her to come to Resident #1's hall to check on her. LVN A said she pushed her nursing cart to where Resident #1 was sitting in her wheelchair. LVN A stated that when she found Resident #1, she was sitting by herself, close to the nurse's station. LVN A said she asked Resident #1 what was wrong. Resident #1 responded she was in pain. LVN A stated she then gave Resident #1 a pain pill. LVN A said sometime before 6:00 PM, she called for someone to take Resident #1 to the dining room to get assistance with eating. LVN A said later (she did not state the time) she witnessed the MD talking to Resident #1 and escorted Resident #1 back to her room. LVN A stated no one told her that Resident #1 had fallen. LVN A stated, during the time of her employment at the facility, she always witnessed a trainee CNA with a fully trained staff in situations where Resident #1 was getting prepped to transfer. LVN A said it was unusual for a trainee CNA to be doing such things by herself. LVN A said at some point, the MD took over doing an assessment on Resident #1 and ordered x-rays. LVN A said dinner started at 5:30 PM. In an interview, on 6-5-2024, at 11:45 AM, CNA C (in training), revealed CNA C stated the fall protocol for the facility was to get a nurse immediately when a resident fell and to not touch or move them. In an interview, on 6-5-2024, at 12:20 PM, with the MD, it was disclosed the MD was at the facility on 5-21-2024 during dinner time. The MD refused to give a more specific time frame. The MD said she was seeing patients during dinner time, with the MDS Coordinator, when Resident #1's [Family Member #2] brought Resident #1 to a TV room, then came to the nurse's station, saying Resident #1 was in pain. MD said LVN A told her she had already given Resident #1 something for pain. The MD said she went to the TV room and asked Resident #1 how she was feeling. Resident #1 responded saying she was in pain. The MD said she then brought Resident #1 back to her room, assessed her, and saw that her left knee was swollen. The MD said she then ordered a stat x-ray and gave Resident #1 Norco pain medicine. In an interview, on 6-5-2024, at 3:00 PM, [Family Member #1] revealed she received a phone call on 5-21-2024, at 5:00 PM, from one of the facility's physical therapists, and told her that Resident #1, was sitting in a hallway crying and that she should have come to the facility and check on her. Resident #1's [Family Member #1] then called Resident #1's [Family Member #2] and told her what the PT told her. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview, on 6-5-2024, at 3:24 PM, [Family Member #2] revealed she had received a phone call from [Family Member #1] informing her that Resident #1 was at the facility crying sitting in a hallway and that she needed to check on Resident #1. Resident #1's [Family Member #2] said she arrived at the facility around 5:40 PM and found Resident #1 in the dining room sitting at a dining table in her wheelchair. Resident #1's [Family Member #2] said Resident #1 told her she was in pain and her left leg hurt. Resident #1 kept saying this repeatedly to Resident #1's [Family Member #2]. As a result, Resident #1's [Family Member #2] started to wheel Resident #1, out of the dining room, to the nurse's station, when CNA A approached Resident #1's [Family Member #2] and told her that CNA A, earlier in the evening, was attempting to change Resident #1's shirt while she was seated on her bed, and Resident #1 fell . CNA A then told Resident #1's [Family Member #2] that Resident #1 was okay as she was eating her food. Resident #1's [Family Member #2] then wheeled Resident #1 to the nurse's station and asked the nurses about Resident #1 falling earlier in the day. Resident #1's [Family Member #2] said the nurses did not know Resident #1 had fallen earlier in the evening. Resident #1's [Family Member #2] said the MD was also at the nurse's station and overheard this conversation. Resident #1's [Family Member #2] said LVN A informed her that Resident #1 had received a Tramadol pill and she was fine. Resident #1's [Family Member #2] then told LVN A that Resident #1 was not fine and was crying in pain. Resident #1's [Family Member #2] then said the MD took Resident #1 and her family member to the dining room, where CNA A told the MD that Resident #1 had fallen earlier in the evening. The MD, Resident #1, and her family member then went to the TV room together, where the MD examined Resident #1. Resident #1's [Family Member #2] said then other staff wheeled Resident #1 back into her room where staff put her back in bed, at which time she screamed in pain. Resident #1's [Family Member #2] said she had never heard Resident #1 scream like that in pain in her entire life. Resident #1's [Family Member #2] said that on a pain scale of 0-10, Resident #1 was past a 10 on 5-21-2024. In an interview, on 6-5-2024 at 4:40 PM, the MDS Coordinator disclosed she assisted Resident #1 back into her bed with CMA B for the MD to finish assessing Resident #1. The MDS Coordinator stated Resident #1 was crying in pain, so she administered Norco to Resident #1. MDS Coordinator did not give a time frame as to when this occurred. In an interview on 6-5-2024, at 4:45 PM, CMA B confirmed that she and the MDS Coordinator transferred Resident #1 back into her bed after 6:00 PM and Resident #1 was crying in pain. Record review on 6-5-2024, at 5:25 PM, of the facility's Pain Management Policy, reflected: All residents will receive the best level of pain control that can safely be provided in order to prevent unrelieved pain. a. Pain is recognized as a vital sign (.) Definition a. PAIN is whatever the experiencing resident says it is, exiting whenever he/she says it is. Self-reporting is the preferred indicator of pain. Behavioral and physiological indicators are used only when resident is unable to self-report. b. Facility uses a self-rating scale 0-10 to evaluate pain. 0 indicates no pain, 10 worst pain imaginable. Facility also uses the face scale to evaluate pain. Smiling face in dates no pain and crying face indicates worst pain imaginable. d. Pain relief is the alleviation of pain or reduction in pain to a level of comfort that is acceptable to the patient (.) e. Multi-model approach to pain management. This is defined as using pharmacological (opioid and non-opioid) interventions and non-pharmacological interventions together to provide comfort (.) Process a. On initial assessment and at regular intervals assess the potential for, the causes of, the onset or presence of and the extent of resident's pain (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6-5-2024, at 5:41 PM, the Administrator was notified that an Immediate Jeopardy had been identified and exited on 5-21-2024, and a copy of the IJ template was provided to the Administrator regarding Pain Management. The following POR was accepted on 6-6-2024 at 3:14 PM: F697 - Failure to adequately assess and treat a resident's pain. F697 - Pain Management [Facility] Plan of Removal [Facility] submits the following Plan of Removal for F697 related to the alleged action of pain by not providing pain medication. By submitting this plan of removal Azle Manor does not admit to the accuracy of the alleged deficient practice. What corrective actions have been implemented for the identified residents? o Residents residing in the facility are assessed for pain every shift and after incidents/accidents. On 6/5/24 the DON/designee completed audits on residents receiving routine and PRN pain medications to determine appropriate timing and resident response to effectiveness of treatment modalities; and On 6/5/24 the DON/designee completed audits on residents with active pain assessments to determine accuracy in level of pain and update the treatment plan How were other residents at risk to be affected by this deficient practice identified? All residents residing in the facility are at risk for pain. Pain assessments are completed every shift, as needed, and following incidents/accidents. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? The DON/designee initiated immediate training on 6/5/24 and completed training on 6/6/24 with CNA Student(s), CNA(s), Medication Aides, and Licensed Nurses to include areas of: o Assessing pain/pain complaints. o Modalities of assessment to include those with communication difficulties and/or cognitive issues. How will the system be monitored to ensure compliance? (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o All new residents will be reviewed by the DON/designee upon admission, after incident/accident, and as needed (PRN) and to assess for presence of pain and ensure that the facility has available medications and non-pharmacological measures to address pain. o DON, ADON, or nurse manager will monitor pain assessments to determine if resident pain is assessed accurately and effectiveness of treatment modalities. Audits on pain assessments, interventions, and effectiveness of treatment will be completed three times weekly x 14 days; then weekly for three months and as needed. o Any discrepancies noted throughout monitoring period will immediately be reviewed by Quality Assurance Team. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6/5/24 with the Medical Director. The Medical Director has reviewed and agrees with this plan. The facility was monitored for compliance with the POR on 6-6-2024 as follows: In an interview on 6-6-2024, at 12:48 PM, LVN B stated: She had been in serviced on pain on the morning of this interview. She said non-licensed staff should get a nurse in the event of any incident with a resident, and the nurse would assess them, including assessing for pain and range of motion. The proper protocol for pain was to assess the level of pain, and provide medication as ordered, then monitor them. if the pain medication was not effective, she would contact the physician to get an order for stronger medication, maybe X-rays. She described the non-verbal signs of pain she would look for. She said they did not want their residents to be in pain. In an interview on 6-6-2024 at 2:45 PM, CNA F stated she had been taught pain protocols to get the nurse if a resident expressed pain. CNA F said the risk to the residents if proper protocols were not followed could be the resident being in increased pain. In an interview on 6-6-2024 at 3:53 PM, CNA G stated she has been in-serviced on pain management on 6-4-2024 and it included signs of pain on a resident, and how to respond. In an interview on 6-6-2024 at 4:15 PM, LVN C stated she was in-serviced on pain, and how do proper pain assessment, find out why a resident was in pain, where the pain was, different signs of pains, non-verbal expression of pain. LVN C said the risk for not following the correct protocols were residents need not being met, and something worse happening, they could stay in pain, and not knowing the cause of pain in their bodies. In an interview on 6-6-2024 at 5:00 PM the DON said going forward, to ensure this kind of situation did not take place again, the residents would be assessed for pain at each shift, and on MDS on admission quarterly and with significant change. She said she was currently auditing pain assessments for accuracy and to see if pharmaceutical and non-pharmaceutical interventions were effective and updating the plans of care. (continued on next page)

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