| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676010 | A. Building<br>B. Wing | 05/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Legacy Rehabilitation and Living | 4033 W 51st Ave<br>Amarillo, TX 79109 |

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) |
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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report to the State Survey Agency an allegation of neglect involving a fall with injury within 2 hours of the allegation for 1 (Resident #1) of 1 resident.The facility failed to report a fall with an injury on [DATE] for Resident #1.This failure could place residents at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and state survey agency. This could place residents at risk of continued and/or unrecognized abuse, neglect, or exploitation.Findings Included:Resident #1Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had a medical history of encounter for orthopedic aftercare following surgical amputation (multi-phase process aimed at protecting the surgical site, promoting healing, and preparing for rehabilitation and prosthetic use), end stage renal disease (chronic kidney disease, where the kidneys can no longer function), Type 2 Diabetes (chronic condition with insulin resistance and high sugar levels), congestive heart failure (heart muscle is unable to pump enough blood to meet the body's need for oxygen and blood), and dependence on renal dialysis (therapy due to kidneys can no longer adequately filter waste and excess fluid from the body). Record review of Resident #1's admission MDS assessment, dated [DATE], revealed a BIMS score of 15, which indicated normal cognitive function. Section GG, Functional Abilities, indicated that Resident #1 needed some help with self-care and functional cognition. Resident utilized a motorized wheelchair and/or scooter. Resident #1 was dependent on all activities of daily living with substantial/maximal assistance for shower/bath self. Record review of Resident #1's baseline care plan, dated [DATE], revealed Resident #1 had a focus of risk for falls related to impaired mobility, visual impairment. Record review of SBAR, dated [DATE], revealed under heading of Situation, the change in condition, symptoms, or signs observed and evaluated is/are: Falls. Record review of Resident #1's progress note, date [DATE] at 5:58 PM, authored by RN A, revealed Resident #1 had fallen in the van. During an interview on [DATE] at 9:10 AM, ED K stated Resident #1 slid out of his wheelchair on the van and that new van driver forgot to check all the residents as she started to drive. During an interview on [DATE] at 9:26 AM, CNA C stated last in-service for abuse, neglect, and exploitation was approximately 3 months ago. CNA C stated that allegations of abuse, neglect, and exploitations are to be reported as soon as they are seen. CNA C stated that a negative outcome of not reporting ANE would be making the resident feel less important and the problem will keep happening without it being reported. During an interview on [DATE] at 9:31 AM, CNA D stated she completed abuse and neglect training upon hire. CNA D stated that a fall with an injury would be reportable and should be reported immediately. CNA D stated that a negative outcome would be an injury of unknown cause and it wouldn't be addressed, which could cause more problems. During an interview on [DATE] at 9:31 AM, CNA E stated it was reportable for a fall with injury and should have been reported immediately. CNA E stated a negative outcome was it could happen again. During an interview on [DATE] at 9:36 AM, CNA F stated an in-service of abuse, neglect, and exploitation was completed last month. CNA F stated she would have reported the fall.<br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA F stated a negative outcome could be the resident could have died. During an interview on [DATE] at 9:41 AM, TA H stated she drove the van on [DATE]. TA stated she wrote a statement of Resident #1's fall on the incident report. TA H stated she forgot to finish buckling Resident #1's wheelchair and when she drove over a pothole, the van began to shake and Resident #1 started to slide out of the wheelchair. TA H stated that every fall was reportable and Resident #1 had no injuries. TA stated she received abuse and neglect training and thought the fall was reported. TA H stated she made OM aware of the fall. TA H stated a negative outcome would be that it could have been bad for the resident. During an interview on [DATE] at 10:00 AM, RT G stated she had seen Resident #1 on the van floor. RT G stated Resident #1 told her he fell on his right side and had pain over his right ribs. RT G stated that MA J assisted with attempt to put Resident #1 in his wheelchair. RT G stated they were not successful as Resident #1 stated he did not want to continue with lifting him to his wheelchair due to pain in ribs. RT G stated she completed abuse and neglect training about 3 months ago. RT G stated that Resident #1's fall was reportable. RT G stated a negative outcome could be permanent damage either physically or psychologically. During an interview on [DATE] at 11:01 AM, LVN I stated that any fall was reportable with a change of plane. LVN I stated a negative outcome was harm to the patient. During an observation and interview on [DATE] at 12:39 PM, Resident #1 a discolored area to the right side of Resident #1's forehead, above the eye was identified. Resident #1 stated that he went flying from his wheelchair on to the van floor. Resident #1 stated his right side was hurting. Resident #1's right side from arm to calf was observed with assistance from DRN D. Bruising identified to Resident #1's right upper arm, right calf area, right flank area (region on the sides of the torso between the lower ribs and the top of the hip bones), right ribs, and right abdomen area. During an interview on [DATE] at 1:03 PM, Resident #2 stated Resident #1 flipped sideways in the van and witnessed Resident #1 hit his head and arms. During an interview on [DATE] at 3:20 PM, SW stated that reporting a fall is contingent on some type of injury. SW stated that a fall should be reported immediately for the injury. SW stated a negative outcome could be significant damage physically or emotionally. During an interview on [DATE] at 3:36 PM, the OM, DON, and ADON were interviewed together. The OM stated for falls was to follow the policy and procedure. Best practice was to complete assessments, notify the nurse practitioner, continue monitoring. The OM stated a fall with injury should be reported as soon as possible. The ADON stated best practice to reach out to the DON and the fall would probably be reportable. The ADON stated the fall should be reported right away. The OM and DON stated a negative outcome of not reporting a fall with injury could be harm to the resident. The ADON stated the worst could be death. During an interview on [DATE] at 11:44 AM, MA J stated Resident #1 was lying along the edge of the van floor between the double doors. MA J asked Resident #1 about assistance with gait belt and Resident #1 declined due to pain in ribs. Record review of policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, revised 04/2025, stated under subheading Alleged Violation- is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse including injury of unknown source, and misappropriate of resident property. Under subheading Procedure it stated: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: A. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment , including injuries of unknown source and misappropriation of resident property, are reported immediately but: -Not later than two hours after the allegation is made if the events that caused the allegation involves abuse or results in serious bodily injury. - Not later than twenty-four hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the resident's environment remained as free from accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 2 residents reviewed for accident hazards. The facility failed to ensure Resident #1 was properly secured/fastened in the facility van resulting in bodily injury to the head, arm, stomach, and leg of Resident #1. An Immediate Jeopardy (IJ) was identified on 05/04/2026 at 4:47 PM. The IJ template was provided to the OM on 05/04/2026 at 5:21 PM. While the immediate jeopardy was lifted on 05/05/2026 at 3:23 PM, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated because all transportation staff had not been trained on 05/05/2026. The Plan of Removal (POR) of IJ will be included in the findings. This failure could place residents at risk for serious physical injury, including fractures, head trauma, or death from falls.Findings included: Resident #1Record review of Resident #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #1 had a medical history of encounter for orthopedic aftercare following surgical amputation (multi-phase process aimed at protecting the surgical site, promoting healing, and preparing for rehabilitation and prosthetic use), end stage renal disease (chronic kidney disease, where the kidneys can no longer function), Type 2 Diabetes (chronic condition with insulin resistance and high sugar levels), congestive heart failure (heart muscle is unable to pump enough blood to meet the body's need for oxygen and blood), and dependence on renal dialysis (therapy due to kidneys can no longer adequately filter waste and excess fluid from the body). Record review of Resident #1's admission MDS assessment, dated 04/28/2026, revealed a BIMS score of 15, which indicated normal cognitive function. Section GG, Functional Abilities, indicated that resident needed some help with self-care and functional cognition. Resident utilized a motorized wheelchair and/or scooter. Resident #1 was dependent on all activities of daily living with substantial/maximal assistance for shower/bath self. Record review of Resident #1's baseline care plan, dated 04/23/2026, revealed Resident #1 had a focus of risk for falls related to impaired mobility, visual impairment. Record review of Resident #1's progress note, dated 04/29/2026 at 5:58 PM, authored by RN A, revealed Resident #1 had fallen in the van. RN A had written that resident reported pain to touch on right side of face and to right upper extremity. Record review of Resident #1's incident report, dated 4/29/2026 at 3:00 PM, revealed under heading Injuries Report Post Incident-Injury Type- Abrasion, Injury Location 1) Top of Scalp. During an interview on 05/01/2026 at 9:10 AM, the ED K stated Resident #1 slid out of his wheelchair on in the van and there was a new driver. The ED K stated that the new van driver forgot to check if all residents were secure before she put the van in motion. ED K stated Resident #1 slid out of his chair and the incident report was still in the process of being completed. During an interview on 05/01/2026 at 9:41 AM, TA H confirmed there was an incident in the van. TA H indicated that she forgot to finish buckling Resident #1 and didn't double check. TA H stated she closed the van doors, went to drive, hit a pothole, and it made the van shake. TA H stated Resident #1 slid out of chair. TA H stated, it was not a hard fall. TA H stated she received one and half days of training and learned how to secure residents on the second day of training. During an interview on 05/01/2026 at 10:00 AM, RT G stated she did not know if Resident #1 hit his head. RT G stated Resident #1 fell on his right side and had pain over his right ribs. RT G stated they asked to assist with sitting the resident up to get his head off the ground. RT G stated Resident #1 refused a lift assist with the gait belt because of the pain in his ribs. During an observation/interview on 05/01/2026 at 12:39 PM, Resident #1 indicated he had pain on his right side the day after the fall. Resident #1 stated he was the last resident on the van. Resident #1 stated TA H only used the strap that connected the wheel to his wheelchair on the back, got in the driver's seat, (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | began to drive, and turned the corner. Resident #1 stated he went flying from his chair. Resident #1 indicated he hit his head and the right side of his body. Assistance from DRN I with observing Resident #1's right side. Resident #1 had bruising identified on right flank, lower right abdomen, right rib area, and on the right calf on the backside. A discolored portion of skin was identified on the right side of Resident #1's forehead. In an interview on 05/01/2026 at 1:03 PM, Resident #2 stated she was on the van the day Resident #1 fell. Resident #2 stated that the bus took off and Resident #1's belts were not secure. Resident #2 stated Resident #1 flipped sideways to the right. Resident #2 stated it was because he was not secured properly. In an interview on 05/01/2026 at 2:14 PM, Resident #3 stated he was on the van the day Resident #1 fell. Resident #3 stated Resident #1 fell in the van, and the chair went over with him. During an interview on 05/04/2026 at 11:15 AM, RT G stated that she went to assist Resident #1 in the van. RT G stated Resident #1 was on the floor of the van in the back. During an interview on 05/04/2026 at 11:24 AM, RN A stated that Resident #1 returned to the facility after completing dialysis treatment. RN A stated that after performing a skin assessment, RN A identified there was a small skin tear to the forehead (less than a millimeter) and Resident #1 complained of back pain. During an interview on 05/04/2026 at 11:44 AM, MA J stated that Resident #1 was lying along the edge of the van between the double doors that were open. MA J stated that Resident #1 reported he thought he was okay, but he felt bruised up. MA J stated that Resident #1 also stated that he may have hit his head. MA J stated Resident #1 may have hit his head as it looked like he had road rash. MA J stated that when attempting to assist to lift Resident #1 with gait belt around the ribs, Resident #1 started groaning and stated it kind-of hurt. During a record review and interview on 05/04/2026 at 11:55 AM, TA H provided a written statement about the incident that occurred with Resident #1. TA H confirmed Resident #1 did not have his seat belt on, per the written statement, and he started sliding out of the wheelchair. During an observation/interview on 05/4/2026 at 12:58 PM, Resident #1 restated the incident that happened on 04/29/2026. Resident #1 stated that TA H locked the strap on the back of van and then went to the front of the van where she sat in the driver's seat. Resident #1 stated TA H took off and went south. Resident #1 stated the van was still in the parking lot of the dialysis center when the fall occurred. Resident #1 stated he was in pain on 05/01/2026. Resident #1 reported pain in his back, above his right eye and bruising on his right side. Resident #1 stated he fell to the right and hit the right side of his stomach. Resident #1 reported he fell completely out of the wheelchair, and the wheelchair was tilted on top of him. Resident #1 stated that there was only one strap on the back wheel. Resident #1 was observed for bruising with photographs obtained. Bruising along the right abdomen, appearing purple and blue in color, was consistent with the arm of a wheelchair. Video taken of Resident #1's power wheelchair showing wheelchair arms were loose. Resident #1 stated this was due to the fall in the van. Resident #1 was observed to have light colored bruises under right arm and right calf area. During an interview on 05/04/2026 at 01:05 PM, Resident #2 stated the wheelchair fell on top of Resident #1 because he was not strapped in. Resident #2 stated that Resident #1 fell on his right side and fell out of the chair. Resident #2 stated Resident #1 was the only one not strapped in that day. During an interview on 05/04/2026 at 2:03 PM, Resident #3 stated Resident #1's wheelchair was not on top of him but leaning on him. Resident #3 stated Resident #1 laid there for a while. During an interview on 05/04/2026 at 4:20 PM, TA H was asked to physically show how Resident #1 was strapped in the van on the day of the fall in the van. TA H stated that the wheelchair provided doesn't strap in the same but with Resident #1, TA H forgot to buckle the lap strap. Record review of undated document, titled Statement for the incident with the van on April 29th, MA J had written Resident #1 stated that maybe his ribs were slightly sore and asked us to look at his forehead as he felt a rug burn sensation on his forehead. Record review of untitled document dated 04/29/2026 revealed TA H's statement recorded as put the patients in the van, was pre-occupied with the seatbelt of another patient after locking and securing Resident #1's wheelchair, that I hadn't noticed that Resident #1 didn't have his seatbelt on. Record review of policy titled Fleet Safety Program, revised 04/14/2021, page 8 under heading 4. (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Preventable/Non-Preventable Accidents, Line B, stated, A preventable accident is defined as any accident/incident involving the vehicle, unless properly parked, which results in property damage or personal injury and in which the driver failed to do everything he/she reasonably could have done to prevent or avoid the accident. Page 14, under section X. Driver Safety Regulation, bullet point 1- The driver and all occupants are required to wear safety belts at all times when the vehicle is in operation or while riding in the vehicle. The driver is responsible for ensuring all passengers, including residents, wear their safety belts and are properly secured in the vehicle at all times using the existing harnesses and restraints. Page 16 under Associate Acknowledgement Statement revealed TA H's printed and signed name providing understanding that she had been trained on these procedures on unknown date. Page 19, under section XI. Wheelchair Securement, it stated, Residents must be secured in their wheelchair and secured in the vehicle before any movement of the vehicle or transportation of any kind is to occur. Record review of Policy/Procedure-Nursing that had a subject of: Fall Management System. The policy section read: It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complication if a fall occurs. The OM was notified that an IJ situation was identified due to the above failures on 05/04/2026 at 4:47 PM. The IJ template was provided on 05/04/2026 at 5:21 PM and plan of removal was requested. The Facility's Plan of Removal (as follows) was accepted on 05/04/2026 at 7:55 PM. It is alleged that the that the facility failed to ensure residents remained as free from accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents.Plan of RemovalProblem: Need for Immediate Action:The IJ documentation provided to the facility on [DATE] states: The facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents when a resident's wheelchair was not secured properly in the van. When the van driver placed the van in motion, the resident fell out of his wheelchair and his wheelchair tipped over on him, resulting in the resident suffering bruising on the right side of his body.Facility plan of Removal states:PLAN OF REMOVALImmediate Jeopardy Tag: F689 - Accidents/SupervisionIJ Identified: 05/04/2026 at 5:21 PMIJ Situation: Failure to ensure residents were properly secured in the facility van, resulting in a resident falling from his wheelchair and sustaining bruising and pain.1. Immediate Corrective Actions Taken to Remove the Jeopardy- Suspension of all resident transportation as of 05/01/2026 at 12:30 PM.- Assessment of injured resident and notification of physician and responsible party.- Removal of involved driver from transport duties.- Restriction of all transport staff pending retraining.2. Systemic Actions to Prevent Recurrence- Mandatory retraining for all transport staff on wheelchair securement, tie-down use, pre-trip checks, emergency procedures, and documentation.- Competency validation for all staff before resuming transport duties.- Inspection and replacement of securement equipment.- Review of Transportation Safety Policy.- Resident risk review and care plan updates.3. Monitoring and Quality Assurance- Daily monitoring of 100% of transports for 14 days.- Weekly administrative review of audits.- QA Committee oversight for six months.4. Date IJ Will Be RemovedAnticipated IJ Removal Date: 05/04/2026.5. Responsible PersonnelAdministrator, Director of Nursing, Maintenance Director,STAFF TRAINING OUTLINE - TRANSPORTATION SAFETY1. Overview of Transportation Risks and Resident Rights2. Wheelchair Securement Procedures (Hands-on)3. Use of Tie-Downs and Occupant Restraint Systems4. Pre-Trip Safety Checklist5. Emergency Procedures During Transport6. Documentation Requirements7. Return Demonstration and Competency Validation TRANSPORTATION SAFETY AUDIT TOOLDate: _____ Time: _____ Auditor: _____Resident Name: _____Wheelchair Secured Correctly (Yes/No)Occupant Restraint Applied (Yes/No)Tie-Downs Checked and Locked (Yes/No)Pre-Trip Checklist Completed (Yes/No)Driver Competency Verified (Yes/No)Comments: _____Corrective Action Needed: _____In-services began 05/05/2026 and all transportation staff to be in-serviced prior to transporting per POR.On 05/05/2026 at 3:23 PM, the state surveyor confirmed the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | facility implemented their plan of removal sufficiently to remove the IJ by:Monitoring of the Plan of Removal Included:In an observation and interview on 05/04/2026 at 6:45 PM, DON and DON L were in Resident #1's room. Resident #1 reported he had a goose egg on his forehead the day of the fall in the van. The DON and DON L viewed the bruising on Resident #1's right side. No additional questions were asked by the DON and DON L to Resident #1.In an observation and interview on 05/05/2026 at 2:56 PM, MA J was observed for competency of training. MA locked wheels after wheelchair was on the van. MA fastened right front strap to wheel, then fastened straps in the following order: left front strap to left front wheel, right back strap to right back wheel, and left back strap to left back wheel. MA fastened the should/lap belt and tightened it. During the demonstration, MA stated he did receive the retraining for transportation as he provides transportation for the facility. In an observation and interview on 05/05/2026 at 3:00 PM, REC O was observed for competency of training. REC O placed chair in the van, locked wheels, and fastened straps in the following order: attached right front strap to right front wheel, right back strap to right back wheel, left back strap to left back wheel, right front strap to right front wheel, and fastened the should/lap strap. REC O stated she did receive the retraining for transportation.In an observation and interview on 05/05/2026 at 3:16 PM, TA H was observed for competency of training. TA H placed wheelchair in the van, locked wheels, and fastened straps in the following order: attached right front strap to right front wheel, right back strap to right back wheel, left front strap to left front wheel, right front strap to right front wheel, and fastened should/lap strap. TA H stated she did receive the retraining for transportation. Record review of a document titled Counseling/Disciplinary Notice dated 5/1/2026, listed TA H as the employee with a check mark by text reading suspension, pending investigation, subject to change. The document was signed by the ADON and TA H, dated 05/01/2026 by both signatures. Attached to the disciplinary action was an in-service training report titled Transportation Driver and Resident Safety, dated 04/30/2026, conducted by ADON. TA signed in-service with training on ensuring safe transport to and from appointments, protect residents from harm during transit, communicate effectively with nursing staff, ensure wheelchair lift/ramp is working, confirm seat belts and restraints are functional, verify emergency equipment is functional and present, lock wheelchair breaks before loading, ensure lap and shoulder belts are properly fastened, recheck restraints before driving, and physically demonstrated proper securement.Record review of in-service In-service and Retraining for Fleet Supervisor after IJ had been started, dated 05/04/2026, revealed MA J completed the training which assisted with creations of binders, check lists, understanding expectations for reporting, and further training for additional staff.Record review of Transportation Audit Tool, dated 05/04/2026 at 10:00 AM, revealed a completed list of wheelchair secured correctly (N/A- no wheelchair), Occupant Restraint applied (Yes), Tie-Downs checked and locked (Yes), Pre-trip checklist completed (Yes), Driver competency verified (Yes), Comments (everything done correctly), Corrective Action Needed (None).Record review of Transportation Audit Tool, dated 05/05/2026 at 09:15 AM, revealed a completed list of wheelchairs secured correctly (Yes), Occupant Restraint applied (Yes), Tie-Downs checked and locked (Yes), Pre-trip checklist completed (Yes), Driver competency verified (Yes), Comments (Everything done correctly), Corrective Action Needed (None). Record review of in-service Transportation, dated 05/05/2026, RT G, TA H, MA J, ED K, and OM completed training covering overview of transportation Risks and Resident's Rights, wheelchair securement procedures, use of tie-downs and occupant restraint systems, pre-trip safety checklist, emergency procedures during transport, documentation requirements, and return demonstration and competency validation. Record review of Resident #1's care plan, dated 05/01/2026, revealed a new focus, goal, and interventions related to fall on 04/29/2026. Record review of Resident #1 progress note, dated 5/2/2026, revealed change of condition for fall with the provider and the resident's responsible party notified. On 05/05/2026 at 3:23 PM, the OM was notified that the IJ was removed. However, the facility remained out of compliance at a scope of isolation and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0837<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.<br><br>Based on interview and record review, the facility failed to ensure the governing body of the facility had appointed an Administrator, who is licensed by the state, to be responsible for the management of the facility and report to the governing body. The facility had not had an Administrator since March 2026. This deficient practice could place residents at risk of decreased quality of life and quality of care due to lack of staff oversight and monitoring of care for all 128 residents at the facility. The findings included: Record review of the facility employee list printed on 5/1/26 by the facility revealed there was no ADM listed. In an interview on 5/1/26 at 8:40 am the former ADM stated he was not the ADM over the building anymore and had his license pulled from the building in March. He stated it had been over 30 days since the facility had had an ADM at the facility. He stated he did not know who the possible new ADM would be. He stated a new ADM had not been officially onboarded, which meant hired. During an interview on 5/1/26 at 10:25 am, the HRD confirmed the former ADM had pulled his license from the facility, but she did not remember when he had done so. She stated March sounded right. She stated she could not give a specific date because the ADM personnel information was located at the corporate office. She stated she did not have any info on the next ADM as he had not been hired yet. In an interview on 5/1/26 at 3:17 pm, the SW stated there was no current ADM and she did not know how long it had been since the facility had had an ADM. She stated she did not know when the facility was getting an ADM. The SW stated she heard there was an ADM coming but she did not know when he would start. In an interview on 5/1/26 at 3:40 pm, the AD stated the facility had not had an ADM since March. She stated she did not know when an ADM would start and she did not know who the new ADM would be. In an interview on 5/1/26 at 4:15 pm, the OM stated he was still in training and would hopefully be finished with his ADM training in the fall or spring. He stated there was not an ADM currently and he stated he did not remember when previous ADM had pulled his license from the building. He stated it was sometime in March. He stated he did not have that information as the corporate office kept information on the ADM. When asked about the consequences for not having an ADM he stated, Good Question. I do not know. Every building needs to have one. He stated there were no policies for having an ADM. |