STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676033	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates	300 Happy LN Hillsboro, TX 76645

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for three (Resident #1, Resident #2, and Resident #4) of five residents reviewed for quality of care. The facility failed to conduct a fall assessment or skin assessment after Resident #1 had a fall on 05/06/24. The facility failed to utilize a two person assist for Resident #1 while providing care, Resident #1 slipped out of bed causing an abrasion to her back and bruising on her face on 05/06/24. The facility failed to document a fall, conduct a fall assessment or a skin assessment after Resident #2 had an unwitnessed fall on 06/23/24 resulting in fractured ribs. The facility failed to document a fall and complete fall and skin assessments after Resident #4 had a fall and was sent to the hospital on 06/02/24 and was diagnosed with a scapula fracture. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 08/26/24 at 7:03 PM. While the IJ was removed on 08/29/24at 4:45 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not receiving necessary medical care, harm, and death. Findings included: Review of Resident #1's quarterly MDS assessment, dated 04/16/24, Section A (Identification Information) reflected a[AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including unspecified dementia, lack of coordination, muscle wasting and atrophy (thinning of muscle tissue due to disuse or nerve problems), and a history of falling. Section C (Cognitive Patterns) reflected no BIMS score as resident was rarely or never understood. She had both long- and short-term memory impairment. Section GG (Functional Abilities) reflected she was dependent for bed mobility and bed to chair transfers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's comprehensive care plan, revised 12/17/23, reflected in part, Resident #1 has an ADL self-care performance deficit related to aggressive behavior, confusion, dementia, and impaired balance. The resident will maintain current level of function in ADLs through the review date. Interventions included, Bed mobility: The resident requires EXTENSIVE assistance by 2 staff to turn and reposition . The resident requires EXTENSIVE assistance by 2 staff with personal hygiene . The resident requires EXTENSIVE assistance by 2 staff for toileting . The resident requires SKIN inspection every day. Observe for redness, open areas, scratches, cuts, bruises, and report to the nurse. A second entry reflected, Resident #1 is high risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. The resident will be free of minor injury through the review date. Interventions included, Anticipate and meet needs, be sure the call light is within reach, follow facility fall protocol. Review of a progress note dated 05/06/24 reflected, Resident noted on floor when writer entered room from hearing scream. Per CNA, during incontinence care resident was turned on side while aide on opposite side providing peri-care when resident sat up and began to slide off of bed onto floor. Red abrasion to mid back noted. No further injuries note at this time. Vitals WNL. Mechanical lift 2-person assist back to bed. MD notified and POA notified. Review of Resident #1's progress notes from 05/07/24 through 05/09/24 reflected no post-fall follow up notes. Review of Resident #1's progress note dated 05/10/24 reflected, [NAME] to yellow bruising noted to left jaw line. Will monitor until resolved. Review of Resident #1's assessment log from 05/06/24 through 05/15/24 reflected no fall assessments. Review of Resident #1's skin observation tool dated 05/10/24, reflected bruising to left jaw line and previous witnessed fall 4 days past. Review of Resident #1's progress note dated 05/12/24 at 1:14 PM, reflected, Family here to visit at lunch. Daughter questioning bruising and swelling to left jaw. Daughter requesting resident go to ER for eval and treatment. Provider notified, okay to send to ER. ADM, DON, ADON notified. Review of Resident #1's radiology reports from the acute hospital, dated 05/12/24 reflected in part, Clinical indication: Injury or trauma, blunt trauma, injury date 05/06/24, injury details: Fall six days ago. The reports reflect a CT of the head, a CT of the cervical spine, and a CT of the face, all without contrast. There were no acute findings on the CT exams. The general instructions reflected the resident was treated for Multiple contusions (bruises) to the nose and left hip. Review of the facility's self-report signed by the ADM, dated 05/14/24, reflected in part, The resident had a recent fall with the result of hitting the nightstand. The Investigation Summary reflected, Resident had a fall previously and resulted in hitting head on nightstand. Review of an undated statement in the self-report folder, written by CNA D, reflected in part, LVN E checked resident and she was a little red on face and scratch on back . Review of a statement dated 05/12/24, written by CNA B, reflected in part, While assisting Resident #1 with her morning meal on 05/06/24, I noticed a slight redness to the left side of her face at the jaw line . On my next shift the following day, I noticed the redness to her jawline was more prominent . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/26/24 at 11:20 AM, LVN A stated she did not work the day Resident #1 fell so she was unaware of injuries. When reminded that she had given Resident #1 medication and written a progress note that day, she stated she did not recall the events of that day. LVN A stated if a resident fell , the nurse was notified and the nurse completed a head-to-toe assessment. She stated the nurse would complete an incident report and a nursing note then document every shift for 72 hours. She stated if it was an unwitnessed fall, they completed neuro checks. She stated she had not had any recent training on falls or the fall policy. During an observation and interview on 08/26/24 at 11:27 AM, CNA B stated Resident #1 fell on the night shift and she worked the day shift. She stated there was a very light bruise on the left side of Resident #1's face from the temple to the chin. She stated it got darker over the next few days. She stated she reported the bruising to LVN A. She stated the furniture in Resident #1's room was in the same position it was in on the day of the fall. Resident #1 was observed lying in bed. The bed was up against the wall on one side and the nightstand was against the wall next to the head of the bed. If resident sat on the edge of the bed, the nightstand would be on her left side. During an interview on 08/26/24 at 12:40 PM, CNA C stated she got report from CNA D the morning after Resident #1 fell . She did not know if anyone was in the room at the time other than CNA D. She stated the resident had a red mark on her back and an area on her face that was blue a couple of days after the fall. She stated she reported the injuries to LVN A. During an interview on 08/26/24 at 1:37 PM, the MDS Nurse stated she updated the care plan after a resident had a fall. She stated she got information from the nursing staff and updated the interventions. She stated she did not keep a fall log or complete a fall assessment. She stated she was not familiar with the facility policy about keeping a fall log. After reviewing Resident #1's comprehensive care plan, the MDS nurse stated no new interventions were implemented after the fall on 05/06/24. During an interview on 08/26/24 at 2:18 PM, the ADON stated it was her expectation that after a fall, the nurse would have assessed the resident, complete a head-to-toe assessment, a post fall assessment, and if the fall was unwitnessed or the resident hit their head, initiated neuro checks. She expected the nurse to write a progress note. The nurse would report to the family and the doctor and initiate an incident report. She stated there was a post-fall assessment form in the electronic medical records but she was not sure if all the staff used that form after a fall. She stated there is a change of condition assessment and some staff may complete that form instead. The ADON stated the electronic medical record system was updated 07/31/24 and since that time, some forms and documents have been renamed. She stated they did not use paper charts for documentation. The ADON stated there was not a fall log instead they used the incident reports to track falls. She stated the MDS Nurse and medical records person were responsible for auditing the incident documentation. Regarding Resident #1's fall on 05/06/24, she stated it was CNA D and LVN E in the room providing care when the resident fell . During an interview on 08/26/24 at 3:03 PM, the ADM stated she did not recall the details from 05/06/24 when Resident #1 fell . She stated she did not initially report the fall because it was witnessed. She stated she reported a few days later after the bruising appeared. She stated she believed it was CNA C who was in the room when the resident fell but she could not recall what other staff member was in the room. She stated the nurse was supposed to assess the resident and notify the doctor after a fall. She stated what they did next varied depending on if the fall was witnessed or not. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 08/26/24 at 3:17 PM, LVN E stated she worked on 05/06/24 when Resident #1 fell . She stated CNA D was in the room by herself when the resident fell . She stated CNA D was the only CNA assigned to the hall that night and maybe that is why there was not a second person in the room. She stated Resident #1 required 2-person assist for care. She stated she was nearby and heard a thump. When she entered the room, the resident was on the floor. She stated she did a body assessment and saw an abrasion on the resident's back but did not see any other injuries. She stated she documented her findings in the medical record and notified the appropriate parties. She stated she reported the fall to the oncoming nurse in shift report. She stated after a fall the nurse was responsible for documenting in the electronic medical record. She stated the nurse would complete a body assessment, notify the doctor and chart in the electronic medical record. She stated neuro checks should be done if the fall was unwitnessed or if the resident hit their head. She stated not monitoring a resident after a fall could result in missing a change in the resident. During a telephone interview on 08/26/24 at 4:45 PM, the primary MD stated he usually got a text from the nurse if there is a fall with no injury or immediate concerns. She stated if there is something requiring more attention, he usually got a phone call. He stated he did not recall the details of Resident #1's fall on 05/06/24. He stated he expected the nurse to complete a thorough assessment after a fall. He stated he expected the nurse would initiate neuro checks if a resident hit their head during a fall. He stated it was very concerning that neuro checks were not completed for this fall as that was part of the standard routine when a resident hit their head. He stated depending on the level or severity of a head injury, there could be multiple negative outcomes. During an interview on 08/27/24 at 11:20 AM, the DON stated he had worked at the facility for a very short time. He stated he had started to build a timeline regarding Resident #1's fall because he believed the facility did everything they should have done for the resident. He stated the documentation was lacking, we missed the mark but that should not rise to the level of an IJ. He stated he had not looked at the documentation on the other residents. He stated they did not know if Resident #1 hit her face during the fall or if the bruise happened sometime later. He stated, But, bruises don't just show up yellow, that is some time into the healing process. He stated the policies provided yesterday were not the right policies as he talked with the corporate and each facility can revise their policies as needed. He stated he had received new policies from a sister facility that were dated. He stated he was still looking for policies in two large binders. During a telephone interview on 08/27/24 at 12:15 PM with CNA C, she stated she was alone in the room with Resident #1, getting her ready for incontinent care, when suddenly, the resident started to sit up in bed then the resident and the bedding started to slide off the bed. She stated the nurse was right there, she just stepped out to get medication when it happened. She stated she tried to hold the bedding but the resident ended up on the floor. She stated LVN E came in and assessed the resident then they used the lift to get the resident back in bed. She remembered there was a red mark on Resident #1's back but does not remember the resident hitting her head or having a red mark on her face. She stated she was aware the resident required two staff for incontinent care. She stated the next time she worked, the resident had started to bruise but she did not remember what color the bruise was. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2. Review of Resident #2's quarterly MDS assessment, dated 06/10/24, Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including unspecified injury of head, unsteadiness on feet, muscle wasting and atrophy (thinning of muscle tissue due to disuse or nerve problems), history of falling, rheumatoid arthritis (a chronic disorder that damages joints and other body systems), and cancer. Section C (Cognitive Patterns) reflected a BIMS score of 2, indicating severely impaired cognition. Section GG (Functional Abilities) reflected the resident required partial/moderate assistance with bed mobility and transfers. Review of Resident #2's comprehensive care plan revised 03/28/24, reflected in part, Focus: The resident is at risk for falls r/t confusion, deconditioning, incontinence. Goal: The resident will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach . Follow facility fall protocol . A second entry revised 06/26/24, reflected I part, Focus: 06/23/24 The resident had an actual fall without injury due to poor balance: fell coming from bathroom without walker. Remind to use walker and get assistance before ambulating. Goal: The resident will resume usual activities without further incident through the review date. Interventions: Continue interventions on the at-risk plan. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document/report PRN for 72 hours to MD for s/sx pain, bruises, change in mental status new onset confusion, sleepiness, inability to maintain posture, agitation. Review of Resident #2's progress notes from 06/21/24 through 06/26/24, reflected in part, a note written 06/24/25 at 2:21 PM, Day 1 post fall: patient is experiencing muscle soreness and is requiring 2 person assist with transfers/ambulating, patient is usually a 1 person assist. A note written 06/25/24 at 8:52 AM Patient this AM was requesting this nurse to send to the ER at this time, reporting, I think I have broken ribs from when I fell . A note written 06/25/24 reflected resident agreed to mobile x-ray coming to the facility. A note written on 06/25/24 at 2:00 PM reflected x-rays were ordered. There was no note describing a fall, a head-to-toe assessment, or any injuries sustained. Review of Resident #2's radiology report dated 06/25/24 at 6:40 PM, reflected in part, Age-indeterminate mildly displaced fracture at anterior ninth rib is noted. Age-indeterminate nondisplaced fracture at anterior sixth to eight ribs are noted. Remaining ribs are without acute findings . Lumbar spine fusion hardware is noted. Review of Resident #2's fall assessment log reflected no fall assessment was completed after the fall on 06/24/24. 3.Review of Resident #4's quarterly MDS assessment dated [DATE], Section A (Identification Information) reflected a [AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including muscle wasting and atrophy (a chronic disorder that damages joints and other body systems), abnormalities of gait and mobility, other lack of coordination, and osteoarthritis (a joint disease that causes breakdown of cartilage and bone). Section C (Cognitive Patterns) reflected a BIMS score of 6 indicating severely impaired cognition. Section GG (Functional Abilities) reflected the resident required substantial/maximal assistance with bed mobility and transfers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #4's comprehensive care plan, revised 12/02/24, reflected in part, Focus: Resident is at risk for falls related to gait/balance problems . Goal: The resident will be free of falls through the review date. Interventions: Remind resident to ask for assistance when transferring. Reminders for safety precautions given not to lean, bend, stoop from wheelchair. Anticipate and meet needs. Ensure call light is in reach and remind resident to use it. Follow facility fall protocol. The resident needs a safe environment. A second entry revised 06/25/24, reflected in part, Resident had an actual fall with skin tear to right wrist and back of hand and a red hematoma to right side of head. Goal: The resident's injured area will resolve without complications by review date. Interventions: Continue interventions on the at-risk plan. Monitor injuries for healing and/or complications. Monitor/document/report PRN for 72 hours to MD for s/sx pain, bruises, change in mental status . Review of Resident #4's progress notes from 05/27/24 through 06/18/24, reflected a note dated 06/02/24 at 11:00 PM, Late Entry: F/U to fall on previous shift. This writer with aide assistance transferred resident back to facility. Family waiting in room upon arrival. Patient seen in emergency room due to fall causing injury to head and right shoulder . Shoulder immobilizer in place. Subsequent notes on 6/3/14 and 6/4/24 reflected the immobilizer in place. None of the notes addressed the head injury. Review of Resident #4's Clinical Report from the acute hospital dated 06/02/24, reflected in part, Chief complaint, fall off a chair. Lost balance. Location of injuries - head and right shoulder. CTs of the head and right shoulder were completed. Clinical impression, Closed nondisplaced acromion fracture of the right scapula. Review of Resident #4's assessment log from 08/31/20 through 08/19/24, reflected no fall assessment or skin assessment after the resident fell on [DATE]. During an observation and interview on 08/26/24 at 11:10 AM, Resident #4 was sitting up in her motorized wheelchair in her room. She held a baby doll in her lap. She denied remembering any falls or injuries recently. She stated she came to this hospital after having the baby. She pointed to the doll on her lap. During an interview on 08/27/24 at 10:45 AM, CNA B stated they learned of the resident's physical abilities from the report from the hospital when they come to the facility. From that report, they would have known if the resident required one or two people for assistance. If she did not have that report, she would have asked the aid from the previous shift how the resident transferred or moved in bed. She stated if the resident required two staff for incontinent care, it was not okay to do it alone. She stated she would grab her partner or the nurse to help. She stated if the resident required two and you did it by yourself, the resident could fall or you could hurt your back. During an interview on 08/27/24 at 11:15 AM, the ADON stated it did not meet her expectations that documentation in the records is not accurate. She stated she expected the nurses to follow the policies. She stated she still believed some of the problems were related to the electronic medical record system being changed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/27/24 at 12:05 PM with CNA F, she stated there were signs in the resident rooms indicating if they required assistance of one or two staff for care and transfers. She stated it was not okay to perform care alone if the resident required 2-person assist. She stated she had to get another aid or even the nurse to help if the resident required two people. She stated doing that by herself could result in skin tears, a fall out of bed, or something else depending on the situation. She stated when a resident fell , she had to notify the nurse and not move the resident until after the nurse had completed an assessment. She stated if she saw a new wound, bruise, or skin issue, she had to notify the nurse immediately. Review of the undated facility policy Falls - Prevention and Risk Reduction reflected in part, The MDS Coordinator will: d. Update interventions on the falls care plan with any new occurrence of falls. Review of the undated facility policy Falls - Risk Assessment and Identification reflected in part, 4. Fall risk assessment must be completed: d. After any fall. Review of the undated facility policy Falls - Post-Fall Protocol reflected in part, 3. The Unit Nurse will: a. Assess the resident from head to toe, and make sure it is safe to assist the resident to a chair before moving him. c. Take a full set of vital signs. e. Interview the resident and any witnesses of the fall to determine the exact circumstances and cause of the fall. f. After the assessment and treatment is done, notify the resident's responsible family member and physician. g. Document the fall in the resident's chart and the 24-hour report. h. [NAME] the spine of the resident's chart for acute charting. i. Fill out and follow through with an Incident Report. 8. The MDS Coordinator will: a. Enter the fall in the Falls Log with its time, date, and location. b. Complete a fall risk assessment which includes a full medication review. c. Add new interventions to the resident's fall risk care plan. Review of the undated facility policy Nursing Documentation reflected in part, 5. Acute Conditions and Incidents: b. A nursing note must be completed every shift each day until the acute condition is resolved. Incidents should be charted every shift for 3 days, and if the incident was a fall, vital signs should be included. The ADM and DON were notified on 08/26/24 at 7:03 PM that an IJ had been identified and an IJ template was provided. The following POR was approved on 08/28/24 at 2:01 PM and indicated the following: The Immediate Jeopardy involves the following concerns: Assessment and documentation to follow up with any incident reports. Root cause of immediate jeopardy: Based on the evidence, documentation has not been completed during after incidents and assessments completed per policy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/26/2024 an abbreviated survey was initiated. On 08/26/2024 the surveyor provided immediate jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes immediate threat to resident health and safety. The notification of immediate jeopardy states as follows: F684 The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Actions taken to remove Immediate Jeopardy: 1. update appropriate policies per facility protocol (DON/ADON) 2. in-service nursing staff on the policy for incident assessment. Anyone not available will be notified via texting system here. Agency and new hires in-servicing before shift. (DON/ADON) 3. Auditing incident reporting x 3 prior months (DON) 4. ensure care plans are accurate (audit) (MDS) These actions will take place on 08/27/2024 and complete by 8/29/2024. Training: DON/designee will update policies as needed immediately to include but not limited to incident reports, documentation and care plans. MDS coordinator will audit all care plans for accuracy. In-service direct nursing staff (full time, prn and agency) on incident reporting, documentation, following the care plan. (ADON complete) ADON will be in-serviced by DON from our sister facility. Notification of in-servicing will be notified via the group texting software at the facility. DON/designee will audit all incident reports weekly for accuracy. This is a process that will be indefinite monitoring process. Monitoring: DON/designee will ensure all incident reports are complete with all assessments completed. These will be audited weekly and discrepancies will be addressed immediately and discussed during QAPI monthly for 3 months. MDS will audit care plans weekly for a month and quarterly afterwards. Any discrepancies will be noted during QAPI. DON/designee will ensure that policies are up to date and changed as needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In-services will be conducted until all direct care staff has been in-serviced and then upon new hire. The facility will keep a check off schedule to ensure accuracy. The Surveyor monitored the POR on 08/29/24 as followed: Review of an in-service conducted on 8/28/24 - 08/29/24 and conducted by the ADON reflected six policies and presentation titled, Untie the Knot Strategies for Unraveling the Complexity of Care Planning in Long Term Care was sent out by text to all staff. 100% of the nursing staff replied via the software program, indicating the material was received and read. Review of the policies updated and reviewed by the DON from 08/27/24 through 08/29/24 and included in the training were as follows: Resident Examination and Assessment Revised April 2007 Neurological Assessment Revised August 2002 Care Plans - Comprehensive Revised October 2009 Accidents and Incidents - Investigating and Reporting Revised July 2017 Charting and Documentation - July 2017 Charting Errors and /or Omissions - December 2006 During interviews and telephone interviews conducted on 08/29/24 from 10:53 AM - 3:50 PM, one RN, four LVNs, and six CNAs from both shifts stated they were in-serviced on falls, assessments, care plans, and 2-person assistance. All staff reported they received the training material via text on 08/28/24 and the staff in the facility reported training at the beginning of their shift. They stated if there was a fall, the nurse would be notified and the resident would be assessed for injuries prior to being moved. The nurse would conduct a head-to toe assessment and note any injuries or skin concerns. All licensed staff stated if the fall was unwitnessed, or the resident hit their head, they would initiate neuro checks. The licensed staff stated they would complete an incident report and document thoroughly in the resident's chart. They stated they would report the fall to the DON, family, and provider immediately after assessing the resident. The licensed staff all stated documentation was imperative because if you did not document, it did not happen. The staff all stated all stated it was important to follow the care plan and have two staff available to provide care when the resident required two staff. Review of an Audit of Incident Reports from 05/02/24 through 07/29/24 and conducted by the DON, reflected all incident reports were reviewed to ensure the provider and responsible party was notified, documentation was initiated, neuro checks were initiated as needed, if injuries were present, and if the resident was sent out for further evaluation. Review of an Audit of care plans completed by the MDS Nurse on 08/29/24, reflected all care plans were reviewed for accuracy and updated as needed. (continued on next page)

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	676033	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates	300 Happy LN Hillsboro, TX 76645

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The ADM was notified on 08/29/24 at 4:45 PM that the IJ had been removed. While the IJ was removed on 08/29/24 at 4:45 PM, the facility remained out of compliance at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44317 Based on interviews and record reviews the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 5 residents reviewed for accidents. The facility failed to ensure Resident #1 received 2-person assistance, as specified in the care plan, when CNA D provided incontinent care independently resulting in Resident #1 falling out of bed on 05/06/24, causing an abrasion on her back and bruising on her face . This failure could place residents at risk of injuries, falls, and a decline in quality of life. Findings included : Review of Resident #1's quarterly MDS assessment, dated 04/16/24, Section A (Identification Information) reflected a[AGE] year-old female admitted to the facility on [DATE]. Section I (Active Diagnoses) reflected diagnoses including unspecified dementia, lack of coordination, muscle wasting and atrophy, and a history of falling. Section C (Cognitive Patterns) reflected no BIMS score as resident was rarely or never understood. She had both long- and short-term memory impairment. Section GG (Functional Abilities) reflected she was dependent for bed mobility and bed to chair transfers. Review of Resident #1's comprehensive care plan, revised 12/17/23, reflected in part, Resident #1 has an ADL self-care performance deficit related to aggressive behavior, confusion, dementia, and impaired balance. The resident will maintain current level of function in ADLs through the review date. Interventions included, Bed mobility: The resident requires EXTENSIVE assistance by 2 staff to turn and reposition . The resident requires EXTENSIVE assistance by 2 staff with personal hygiene . The resident requires EXTENSIVE assistance by 2 staff for toileting . The resident requires SKIN inspection every day. Observe for redness, open areas, scratches, cuts, bruises, and report to the nurse. A second entry reflected, Resident #1 is high risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. The resident will be free of minor injury through the review date. Interventions included, Anticipate and meet needs, be sure the call light is within reach, follow facility fall protocol. Review of a progress note dated 05/06/24 reflected, Resident noted on floor when writer entered room from hearing scream. Per CNA, during incontinence care resident was turned on side while aide on opposite side providing peri-care when resident sat up and began to slide off of bed onto floor. Red abrasion to mid back noted. No further injuries note at this time. Vitals WNL. Mechanical lift 2-person assist back to bed. MD notified and POA notified . Review of Resident #1's progress notes from 05/07/24 through 05/09/24 reflected no post-fall follow up notes. Review of Resident #1's progress note dated 05/10/24 reflected, [NAME] to yellow bruising noted to left jaw line. Will monitor until resolved. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's assessment log from 05/06/24 through 05/15/24 reflected no fall assessments. Review of Resident #1's skin observation tool dated 05/10/24, reflected bruising to left jaw line and previous witnessed fall 4 days past. Review of Resident #1's progress note dated 05/12/24 at 1:14 PM reflected, Family here to visit at lunch. Daughter questioning bruising and swelling to left jaw. Daughter requesting resident go to ER for eval and treatment. Provider notified, okay to send to ER. ADM, DON, ADON notified. Review of Resident #1's radiology reports from the acute hospital, dated 05/12/24 reflected in part, Clinical indication: Injury or trauma, blunt trauma, injury date 05/06/24, injury details: Fall six days ago. The reports reflect a CT of the head, a CT of the cervical spine, and a CT of the face, all without contrast. There were no acute findings on the CT exams. The general instructions reflected the resident was treated for Multiple contusions (bruises) to the nose and left hip. Review of the facility's self-report signed by the ADM, dated 05/14/24, reflected in part, The resident had a recent fall with the result of hitting the nightstand. The Investigation Summary reflected, Resident had a fall previously and resulted in hitting head on nightstand. Review of an undated statement in the self-report folder, written by CNA D, reflected in part, While changing Resident #1 she started sitting up in middle of brief change, she started sliding off bed . LVN E checked resident and she was a little red on face and scratch on back . We set her down sitting next to bed that is when she got scratch. Review of a statement dated 05/12/24, written by CNA B, reflected in part, While assisting Resident #1 with her morning meal on 05/06/24, I noticed a slight redness to the left side of her face at the jaw line . On my next shift the following day, I noticed the redness to her jawline was more prominent . During an interview on 08/26/24 at 11:20 AM, LVN A stated she did not work the day Resident #1 fell so she was unaware of injuries. When reminded that she had given Resident #1 medication and written a progress note that day, she stated she did not recall the events of that day. LVN A stated if a resident fell , the nurse was notified and the nurse completed a head-to-toe assessment. She stated the nurse would complete an incident report and a nursing note then document every shift for 72 hours. She stated if it was an unwitnessed fall, they completed neuro checks. She stated she had not had any recent training on falls or the fall policy. During an observation and interview on 08/26/24 at 11:27 AM, CNA B stated Resident #1 fell on the night shift and she worked the day shift. She stated there was a very light bruise on the left side of Resident #1's face from the temple to the chin. She stated it got darker over the next few days. She stated she reported the bruising to LVN A. She stated the furniture in the Resident #1's room was in the same position it was in on the day of the fall. Resident #1 was observed lying in bed. The bed was up against the wall on one side and the nightstand was against the wall next to the head of the bed. If resident sat on the edge of the bed, the nightstand would be on her left side. During an interview on 08/26/24 at 12:40 PM, CNA C stated she got report from CNA D in the morning after Resident #1 fell . She did not know if anyone was in the room at the time other than CNA D. She stated the resident had a red mark on her back and an area on her face that was blue a couple of days after the fall. She stated she reported the injuries to LVN A. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/26/24 at 1:37 PM, the MDS Nurse stated she updated the care plan after a resident had a fall. She stated she got information from the nursing staff and updated the interventions. She stated she did not keep a fall log or complete a fall assessment. She stated she was not familiar with the facility policy about keeping a fall log. After reviewing Resident #1's comprehensive care plan, the MDS nurse stated no new interventions were implemented after the fall on 05/06/24. During an interview on 08/26/24 at 2:18 PM, the ADON Stated it was her expectation that after a fall, the nurse would have assessed the resident, complete a head-to-toe assessment, a post fall assessment, and if the fall was unwitnessed or the resident hit their head, initiated neuro checks. She expected the nurse to write a progress note. The nurse would report to the family and the doctor and initiate an incident report. She stated there was a post-fall assessment form in the electronic medical records but she was not sure if all the staff used that form after a fall. She stated there is a change of condition assessment and some staff may complete that form instead. The ADON stated the electronic medical record system was updated 07/31/24 and since that time, some forms and documents have been renamed. She stated they did not use paper charts for documentation. The ADON stated there was not a fall log instead they used the incident reports to track falls. She stated the MDS Nurse and medical records person were responsible for auditing the incident documentation. Regarding Resident #1's fall on 05/06/24, she stated it was CNA D and LVN E in the room providing care when the resident fell . During an interview on 08/26/24 at 3:03 PM, the ADM stated she did not recall the details from 05/06/24 when Resident #1 fell . She stated she did not initially report the fall because it was witnessed. She stated she reported a few days later after the bruising appeared. She stated she believed it was CNA C who was in the room when the resident fell but she could not recall what other staff member was in the room. She stated the nurse was supposed to assess the resident and notify the doctor after a fall. She stated what they did next varied depending on if the fall was witnessed or not. During a telephone interview on 08/26/24 at 3:17 PM, LVN E stated she worked on 05/06/24 when Resident #1 fell . She stated CNA D was in the room by herself when the resident fell . She stated CNA D was the only CNA assigned to the hall that night and maybe that is why there was not a second person in the room. She stated Resident #1 required 2-person assist for care. She stated she was nearby and heard a thump. When she entered the room, the resident was on the floor. She stated she did a body assessment and saw an abrasion on the resident's back but did not see any other injuries. She stated she documented her findings in the medical record and notified the appropriate parties. She stated she reported the fall to the oncoming nurse in shift report. She stated after a fall the nurse was responsible for documenting in the electronic medical record. She stated the nurse would complete a body assessment, notify the doctor and chart in the electronic medical record. She stated neuro checks should be done if the fall was unwitnessed or if the resident hit their head. She stated not monitoring a resident after a fall could result in missing a change in the resident. During a telephone interview on 08/26/24 at 4:45 PM, the primary MD stated he usually got a text from the nurse if there is a fall with no injury or immediate concerns. She stated if there is something requiring more attention, he usually got a phone call. He stated he did not recall the details of Resident #1's fall on 05/06/24. He stated he expected the nurse to complete a thorough assessment after a fall. He stated he expected the nurse would initiate neuro checks if a resident hit their head during a fall. He stated it was very concerning that neuro checks were not completed for this fall as that was part of the standard routine when a resident hit their head. He stated depending on the level or severity of a head injury, there could be multiple negative outcomes. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 08/27/24 at 11:20 AM, the DON stated had worked at the facility for a very short time. He stated they did not know if Resident #1 hit her face during the fall or if the bruise happened sometime later. He stated, But, bruises don't just show up yellow, that is some time into the healing process. During a telephone interview on 08/27/24 at 12:15 PM, with CNA C, she stated she was alone in the room with Resident #1, getting her ready for incontinent care, when suddenly, the resident started to sit up in bed then the resident and the bedding started to slide off the bed. She stated the nurse was right there, she just stepped out to get medication when it happened. She stated she tried to hold the bedding but the resident ended up on the floor. She stated LVN E came in and assessed the resident then they used the lift to get the resident back in bed. She remembered there was a red mark on Resident #1's back but does not remember the resident hitting her head or having a red mark on her face. She stated she was aware the resident required two staff for incontinent care. She stated the next time she worked, the resident had started to bruise but she did not remember what color the bruise was. During an interview on 08/27/24 at 10:04 AM, a policy for ADLs was requested from the ADM. She stated she would look for the policy. During an interview on 08/27/24 at 10:45 AM, CNA B stated they learned of the resident's physical abilities from the report from the hospital when they come to the facility. From that report, they would have known if the resident required one or two people for assistance. If she did not have that report, she would have asked the aid from the previous shift how the resident transferred or moved in bed. She stated if the resident required two staff for incontinent care, it was not okay to do it alone. She stated she would grab her partner or the nurse to help. She stated if the resident required two and you did it by yourself, the resident could fall or you could hurt your back. During an interview on 08/27/24 at 11:20 AM, a policy for ADLs was requested from the DON. He stated he would look in the binders for the policy. During an interview on 08/27/24 at 12:05 PM with CNA F, she stated there were signs in the resident rooms indicating if they required assistance of one or two staff for care and transfers. She stated it was not okay to perform care alone if the resident required 2-person assist. She stated she had to get another aid or even the nurse to help if the resident required two people. She stated doing that by herself could result in skin tears, a fall out of bed, or something else depending on the situation. She stated when a resident fell , she had to notify the nurse and not move the resident until after the nurse had completed an assessment. She stated if she saw a new wound, bruise, or skin issue, she had to notify the nurse immediately. Review of the facility in-service records from May through July 2024, reflected a Falls and Resident Rights in-service was conducted on 05/13/24. Review of the undated facility policy Falls - Risk Assessment and Identification reflected in part, 6. c. The Nursing Assistant Care form must indicate the resident's i. Weight-bearing status ii. Balance problems iii. Method of transfer iv. Transfer aids v. How many staff members are required for transfer and ambulation. No policy on ADLs was received prior to exit.