STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676094	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Orange	4201 Fm 105 Orange, TX 77630

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review, the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of property, and exploitation for 4 of 17 residents (Residents #1, #2, #3, and #4) reviewed for abuse. 1. The facility failed to ensure Resident #3 did not hit Resident #4 on 10/05/24. 2. The facility failed to ensure Resident #1 did not hit and push Resident #2 on 11/11/24. The noncompliance was identified as PNC. The noncompliance began on 10/05/24 and ended on 11/11/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk for emotional distress, fear, decreased quality of life and further abuse. Findings included: 1. Record review of Resident #3's face sheet dated 01/14/25 indicated she was a [AGE] year -old female, admitted on [DATE], and her diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), COPD (Chronic obstructive pulmonary disease is an ongoing lung condition caused by damage to the lung), anxiety (emotion characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events) and bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks). Record review of Resident #3's annual MDS dated [DATE] indicated she was able to make herself understood, usually understood others, was cognitive (BIMS-15), exhibited no behaviors, and utilized a wheelchair for mobility. She required supervision to moderate assistance for all ADLS. Record review of Resident #3's progress note, dated 10/05/24 at 12:30 p.m., completed by LVN K, indicated Resident #3 slapped Resident #4 in the face. Resident #3 stated [Resident #4] slapped me on the back of the head and scratched me so I defended myself. Small skin tear noted on Resident #3's left forearm. On-call notified and gave a new order for treatment of skin tear. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's psychiatric visit report, dated 10/08/24, completed by NP D, indicated Resident #3 agreed to restart Abilify (used to treat agitation and bipolar disorder). Record review of Resident #3's care plan, dated 10/24/24, indicated she was on medication for bipolar and interventions included administer medications as ordered and monitor/record occurrence of targeted behavior. 2. Record review of Resident #4's face sheet dated 01/14/25 indicated she was an [AGE] year old female, admitted on [DATE], and her diagnoses included Alzheimer's (brain disorder that causes problems with memory, thinking and behavior) Record review of Resident #4's quarterly MDS assessment, dated 10/23/24, indicated was usually able to make herself understood and understood others, had moderate cognitive impairment (BIMS 11), had no behaviors, utilized a wheelchair for mobility, and required partial to maximum assist for all ADLS. Record review of Resident #4's care plan dated 07/06/24 indicated she had the potential to be physically aggressive related to Alzheimer's. Interventions included communication and to provide physical and verbal cues to alleviate anxiety and redirect to nurse's station. Record review of Resident #4's progress note dated 10/05/24, completed by LVN N, indicated Resident #4 pushed Resident #3. Resident #3 slapped Resident #4 on the right side of her face. Bruise noted to the right side of the face, Resident #3 denied pain. Resident refused pain medications and stated, I am not a baby it was just a slap. Record review of Resident #4's psychiatric visit report dated 10/16/24, completed by NP D, indicated Resident #4 did not recall who hit her, said she had memory problems, and did not want to talk about the incident. There were no medication changes. Record review of the facility investigation, dated 10/11/24 and completed by the Administrator, indicated the facility confirmed the incident occurred. The facility indicated the incident occurred on 10/5/24 at 11:30 a.m. The facility reported the incident to HHS on 10/06/24 at 10:19 a.m. On 10/05/24 the facility in-serviced staff on the abuser/neglect policy and keeping Resident #3 and Resident #4 separated. During an interview on 01/10/25 at 9:00 a.m., the DON said Residents #3 and #4 used their wheelchairs for mobility. She said Resident #4 sometimes had difficulty and bumped into others. It was alleged Resident #3 slapped Residents #4's face and left a bruise. She said the bruise was actually an age spot. The residents were separated, and staff were in-serviced to keep residents separated. Both residents were seen by psych services and Resident #3's medications were adjusted. There was no history of aggression between the residents and there has been no issues since the incident. During an interview on 01/13/25 at 1:00 p.m., Resident #3 said she had no recollection of any issues or physical altercations with any other resident. She said she was not afraid of any residents. She said she had no complaints of her care of staff. She said she would report any abuse to the DON or Administrator . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/14/25 at 11:00 a.m., Resident #4 said she did not remember any issues or physical altercations with any other resident. She said she was not afraid of any residents. She said she had no complaints of her care of staff. She said she would report any abuse to the DON or Administrator. 3. Record review of Resident #1's face sheet dated 01/13/25 indicated he was an [AGE] year old male, admitted on [DATE], and his diagnoses included spondylosis (degeneration of the vertebral column from any cause) and acute kidney failure (sudden decline in kidney function). Record review of Resident #1's MDS assessment (discharge) dated 11/15/24 indicated he had moderate cognitive impairment (BIMS of 11) required set up/supervision or partial assist for ADLS, had physician behavioral symptoms directed at others and verbal behavioral symptoms directed at others. Record review of Resident #1's care plan, dated 09/20/24, indicated no behavioral focus or interventions. Record review of a progress note, dated 11/11/24 completed by LVN A, indicated LVN A was notified by an unidentified aide that Resident #1 hit Resident #2. LVN A observed Resident #1 lying on his bed. Resident #1 smiled and stated [Resident #2] wouldn't shut up. I sat up on my side of the bed. I walked over to him, and [Resident #2] shoved me in my face. Then I pushed him back. LVN A observed Resident #1 for bruising that was located on the left side of his head. Family and physician notified. Resident #1 moved to another room. Record review of a progress note, dated 11/15/24, indicated Resident #1 was discharged to home. 4. Record review of Resident #2's face sheet dated 01/13/25 indicated he was a [AGE] year old male, admitted on [DATE], and his diagnoses included Parkinson's (disease is a movement disorder of the nervous system that worsens over time) and Alzheimer's (brain disorder that causes problems with memory, thinking and behavior) Record review of Resident #2's quarterly MDS assessment, dated 12/11/24, indicated he was able to make himself understood and usually understood others, he was cognitively intact with a (BIMS of 15), had no behaviors, utilized a wheelchair or walker for mobility, and required set up or supervision for some ADLS. Record review of Resident #2's care plan, dated 10/30/24, indicated Resident #2 was verbally aggressive. Interventions included positive feedback for good behavior . Record review of Resident #2's care plan dated 11/11/24 indicated he received physical aggression from another resident. Interventions included physician notification, separation of residents and the other resident moved to a different room to prevent further incidents. Record review of Resident #2's progress note, dated 11/11/24 ,and completed by LVN A, indicated Resident #2 was on the floor. Resident #2 stated Resident #1 pushed him. Resident #2 had a skin tear on his left forearm and left elbow. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/13/25 at 9:47 a.m., Resident #2 said Resident #1 came over to his side of the room and Resident #1 popped him on his head. He said he pushed Resident #1 away and then Resident #1 pushed him (Resident #2) and he fell over his bed to the floor. He said he hurt his shoulder. He said Resident #1 was taken out of the room right away and moved to another room. He said he could not recall why Resident #1 hit him or pushed him. He said it was abuse to be hit and pushed but he was not afraid of Resident #1 . During an interview on 01/13/25 at 8:45 a.m., the DON said she did not know the reason the incident between Resident #1 and Resident #2 was not reported. She said she was notified of the incident and notified the Administrator immediately. She said resident to resident abuse was reportable to the state. She said Resident #1 and Resident #2 were immediately separated with Resident #1 being moved to a different room. She said staff were trained prior to the incident and after the incident on abuse, neglect, and reporting. During an interview on 01/13/25 at 9:00 a.m., the Administrator said he was the abuse coordinator. He said he did not report the incident between Resident #3 and Resident #4 within 2 hours because there was no serious injury. He said he did not report the incident between Resident #1 and Resident #2 as resident to resident abuse because it was two residents going back and forth and there was no serious injury. He said Resident #1 was moved immediately to another room. He said there was no history of incidents between Resident #1 or Resident #2. He said allegations or incidents of abuse were reportable within 2 hours. He said the facility followed the facility policy and most recent provider letter regarding reporting abuse. He said residents were at risk of continued abuse if allegations of abuse was were not reported as required . During an interview on 01/16/25 at 12:31 a.m., LVN A said she was not in the room when Resident #1 pushed and hit Resident #2. She said Resident #2 was yelling that he had stood up and Resident #1 pushed him to the floor. She said she immediately separated the two residents to different rooms and notified the DON. She said there was no history of aggression between Resident #1 and Resident #2 . She said there was no further incidents after they were separated. Interviews conducted on 01/10/25 from 8:30 a.m. through 3:30 p.m., 01/13/25 from 8:30 a.m. through 3:30 p.m., 01/14/25 from 8:30 a.m. through 3:30 p.m. and 01/15/25 from 8:30 a.m. through 2:30 p.m. with the Administrator, the DON, 1 RN (RN B), 6 LVN (LVN A, LVN H, LVN I, LVN J, LVN K, LVN L), 9 CNA (CNA C, CNA M, CNA N, CNA O, CNA P, CNA W, CNA X, CNA Y, CNA Z), 2 housekeeping staff (HSK Q, HSK S), 2 dietary staff (DT AA, DT BB), and 1 maintenance staff (MS R who represented all shifts (6:00 a.m.-2:00 p.m., 2:00 p.m. -10:00 p.m., and 10:00 p.m.-6:00 a.m.) indicated they were able to give examples of abuse (physical, sexual, emotional, psychological) and neglect (not providing services) and would report immediately to the abuse coordinator or designee. Interviews conducted with 12 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) on 01/10/25 from 8:30 a.m. through 3:30 p.m., 01/13/25 from 8:30 a.m. through 3:30 p.m., 01/14/25 from 8:30 a.m. through 3:30 p.m. and 01/15/25 from 8:30 a.m. through 2:30 p.m. indicated there were no concerns of abuse and they would report any abuse to the administrator and DON immediately. They were not afraid of any staff or other residents. They had no complaints of staff or fear of any resident . Record review of in-service, dated 10/05/24, 11/02/24, and 11/22/24 indicated staff who represented all shifts were retrained on abuse and neglect prevention and reporting. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's abuse policy, dated 02/01/17 (revised 01/27/20), indicated The purpose of this policy is to ensure that each resident has the right to be free from any type of Abuse, Neglect, Intimidation, Involuntary Seclusion, Confinement, and or Misappropriation of property. The facility staff will adhere to the policies and procedures and will follow the guidelines in the written policy and procedure. Residents will not be subjected to abuse by anyone, including but not limited to community staff other residents The noncompliance was identified as PNC. The noncompliance began on 10/05/24 and ended on 11/11/24. The facility had corrected the noncompliance before the survey began.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interviews and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported, immediately but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or bodily injury, to the administrator of the facility and to other officials, including the State Survey Agency in accordance with State law through established procedures for 4 of 17 residents (Residents #1, #2, #3 and #4) reviewed for reporting allegations of abuse. 1. The facility failed to report an allegation of abuse within 2 hours after Resident #3 slapped Resident #4's face on 10/05/24. 2. The facility failed to report an allegation of abuse within 2 hours after Resident #1 hit and pushed Resident #2 on 11/11/24. These failures could place residents at risk of abuse, physical harm, mental anguish and emotional distress. Findings include: 1. Record review of Resident #3's face sheet, dated 01/14/25, indicated a [AGE] year old female, admitted to the facility on [DATE]. Resident #3 had diagnoses which included dementia (group of symptoms that affects memory, thinking and interferes with daily life), COPD (an ongoing lung condition caused by damage to the lung), anxiety (emotion characterized by an unpleasant state of inner turmoil and includes feelings of dread over anticipated events) and bipolar disorder (a mental disorder characterized by periods of depression and periods of abnormally elevated mood that each last from days to weeks). Record review of Resident #3's annual MDS, dated [DATE], indicated she was able to make herself understood, usually understood others, was cognitive evidenced by a BIMS 15, exhibited no behaviors, and utilized a wheelchair for mobility. She required supervision to moderate assistance for all ADLS. Record review of Resident #3's progress note, dated 10/05/24 at 12:30 p.m., completed by LVN K, indicated Resident #3 slapped Resident #4 in the face. Resident #3 stated [Resident #4] slapped me on the back of the head and scratched me so I defended myself. A small skin tear noted on Resident #3's left forearm. On-call notified and gave a new order for treatment of skin tear. Record review of Resident #3's psychiatric visit report, dated 10/08/24, completed by NP M, indicated Resident #3 agreed to restart Abilify (used to treat agitation and bipolar disorder). Record review of Resident #3's care plan, dated 10/24/24, indicated she was on medication for bipolar and interventions included administer medications as ordered and monitor/record occurrence of targeted behavior. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #4's face sheet, dated 01/14/25, indicated an [AGE] year old female, admitted to the facility on [DATE]. Resident #4 had a diagnosis which included Alzheimer's (brain disorder that causes problems with memory, thinking and behavior.) Record review of Resident #4's quarterly MDS assessment, dated 10/23/24, indicated the resident was usually able to make herself understood and understood others, had moderate cognitive impairment with a BIMS of 11, had no behaviors, utilized a wheelchair for mobility, and required partial to maximum assist for all ADLS. Record review of Resident #4's care plan, dated 07/06/24, indicated she had the potential to be physically aggressive related to Alzheimer's. Interventions included communication and to provide physical and verbal cues to alleviate anxiety and redirect to the nurse's station. Record review of Resident #4's progress note, dated 10/05/24, completed by LVN N, indicated Resident #4 pushed Resident #3. Resident #3 slapped Resident #4 on the right side of her face. A bruise noted to the right side of the face, Resident #3 denied pain. The Resident refused pain medications and stated I am not a baby it was just a slap. Record review of Resident #4's psychiatric visit report, dated 10/16/24, completed by NP D, indicated Resident #4 did not recall who hit her, she said she had memory problems, and did not want to talk about the incident. There were no medication changes. Record review of the facility investigation, dated 10/11/24 and completed by the Administrator, indicated the facility confirmed the incident occurred. The facility indicated the incident occurred on 10/5/24 at 11:30 a.m. The facility reported the incident to HHS on 10/06/24 at 10:19 a.m. On 10/05/24 the facility in-serviced staff on the abuser/neglect policy and kept Resident #3 and Resident #4 separated. During an interview on 01/10/25 at 9:00 a.m., the DON said Residents #3 and #4 used their wheelchairs for mobility. She said Resident #4 sometimes had difficulty and bumped into others. It was alleged Resident #3 slapped Residents #4's face and left a bruise. She said the bruise was actually an age spot. The residents were separated and staff were in-serviced to keep residents separated. Both residents were seen by psych services. There was no history of aggression between the residents and there had been no issues since the incident. 3. Record review of Resident #1's face sheet, dated 01/13/25, indicated an [AGE] year old male, admitted to the facility on [DATE]. Resident #1 had diagnoses which included spondylosis (degeneration of the vertebral column from any cause) and acute kidney failure (sudden decline in kidney function). Record review of Resident #1's Discharge MDS assessment, dated 11/15/24, indicated he had moderate cognitive impairment with a BIMS of 11, required set up/supervision or partial assist for ADLS, had physician behavioral symptoms directed at others and verbal behavioral symptoms directed at others. Record review of Resident #1's care plan, dated 09/20/24, indicated no behavioral focus or interventions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a progress note, dated 11/11/24, completed by LVN A, indicated LVN A was notified by an unidentified aide that Resident #1 hit Resident #2. LVN A observed Resident #1 lying in his bed. Resident #1 smiled and stated Resident #2 wouldn't shut up. I sat up on my side of the bed. I walked over to him and Resident #2 shoved me in my face. Then I pushed him back. LVN A observed Resident #1 for bruising that was located on the left side of his head. Family and physician notified. Resident #1 moved to another room. Record review of a progress note, dated 11/15/24, indicated Resident #1 was discharged to home on 11/15/24. 4. Record review of Resident #2's face sheet, dated 01/13/25, indicated a [AGE] year old male, admitted to the facility on [DATE]. Resident #2 had diagnoses which included Parkinson's (disease is a movement disorder of the nervous system that worsens over time) and Alzheimer's (brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.) Record review of Resident #2's quarterly MDS assessment, dated 12/11/24, indicated he was able to make himself understood and usually understood others, he was cognitively intact with a BIMS 15, had no behaviors, utilized a wheelchair or walker for mobility, and required set up or supervision for some ADLS. Record review of Resident #2's care plan, dated 10/30/24, indicated Resident #2 was verbally aggressive. Interventions included positive feedback for good behavior. Record review of Resident #2's care plan 11/11/24 indicated he received physical aggression from another resident. Interventions included physician notification, separation of residents and other resident moved to a different room to prevent further incidents. Record review of Resident #2's progress note, dated 11/11/24 and completed by LVN A, indicated Resident #2 was on the floor. Resident #2 stated Resident #1 pushed him. Resident #2 had a skin tear on his left forearm and left elbow. During an interview on 01/13/25 at 8:45 a.m., the DON said she did not know the reason the incident between Resident #1 and Resident #2 was not reported. She said she was notified of the incident and notified the Administrator immediately. She said resident to resident abuse was reportable to the state. She said Resident #1 and Resident #2 were immediately separated with Resident #1 being moved to a different room. She said staff were trained prior to the incident and after the incident on abuse, neglect and reporting. During an interview on 01/13/25 at 9:00 a.m., the Administrator said he was the abuse coordinator. He said he did not report the incident between Resident #3 and Resident #4 within 2 hours because there was no serious injury. He said he did not report the incident between Resident #1 and Resident #2 as resident to resident abuse because it was two residents going back and forth and there was no serious injury. He said Resident #1 was moved immediately to another room. He said there was no history of incidents between Resident #1 or Resident #2. He said an allegation or incidents of abuse were reportable within 2 hours. He said the facility followed the facility policy and most recent provider letter regarding reporting abuse. He said residents were at risk of continued abuse if allegations of abuse were not reported as required. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/16/25 at 12:31 a.m., LVN A said she was not in the room when Resident #1 pushed and hit Resident #2. She said Resident #2 was yelling that he had stood up and Resident #1 pushed him to the floor. She said she immediately separated the two residents to different rooms and notified the DON. She said there was no history of aggression between Resident #1 and Resident #2. She said there was no further incidents after they were separated. She said all resident-to-resident abuse was reportable immediately to the DON and Administrator. Record review of the facility's abuse policy, dated 02/01/17 (revised 01/27/20), indicated . Reporting and Investigating: The law requires the abuse coordinator/designee, or employee of the facility who believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person to report the abuse, neglect or exploitation. All events that involve an allegation of abuse or involve a suspicious serious bodily injury of unknown origin must be reported immediately or not later than 2 hours of alleged violation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on interview and record review the facility failed investigate and report the findings of the investigation to the State Survey Agency within 5 working days of the incident for 2 of 17 residents (Residents #1 and #2) reviewed for abuse. The facility failed to investigate and submit the results of their investigation within 5 days after Resident #1 hit and pushed Resident #2. These failures could place residents at risk of abuse, physical harm, mental anguish and emotional distress. Findings included: Record review of Resident #1's face sheet, dated 01/13/25, indicated an [AGE] year old male, admitted to the facility on [DATE]. Resident #1 had diagnoses which included spondylosis (degeneration of the vertebral column from any cause) and acute kidney failure (sudden decline in kidney function). Record review of Resident #1's Discharge MDS assessment, dated 11/15/24, indicated he had moderate cognitive impairment with a BIMS of 11, required set up/supervision or partial assist for ADLS, had physician behavioral symptoms directed at others and verbal behavioral symptoms directed at others. Record review of Resident #1's care plan, dated 09/20/24, indicated no behavioral focus or interventions. Record review of a progress note, dated 11/11/24, completed by LVN A, indicated LVN A was notified by an unidentified aide that Resident #1 hit Resident #2. LVN A observed Resident #1 lying in his bed. Resident #1 smiled and stated Resident #2 wouldn't shut up. I sat up on my side of the bed. I walked over to him and Resident #2 shoved me in my face. Then I pushed him back. LVN A observed Resident #1 for bruising that was located on the left side of his head. Family and physician notified. Resident #1 moved to another room. Record review of a progress note, dated 11/15/24, indicated Resident #1 was discharged to home on 11/15/24. Record review of Resident #2's face sheet, dated 01/13/25, indicated a [AGE] year old male, admitted to the facility on [DATE]. Resident #2 had diagnoses which included Parkinson's (disease is a movement disorder of the nervous system that worsens over time) and Alzheimer's (brain disorder that causes problems with memory, thinking and behavior. This is a gradually progressive condition.) Record review of Resident #2's quarterly MDS assessment, dated 12/11/24, indicated he was able to make himself understood and usually understood others, he was cognitively intact with a BIMS 15, had no behaviors, utilized a wheelchair or walker for mobility, and required set up or supervision for some ADLS. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, dated 10/30/24, indicated Resident #2 was verbally aggressive. Interventions included positive feedback for good behavior. Record review of Resident #2's care plan 11/11/24 indicated he received physical aggression from another resident. Interventions included physician notification, separation of residents and other resident moved to a different room to prevent further incidents. Record review of Resident #2's progress note, dated 11/11/24 and completed by LVN A, indicated Resident #2 was on the floor. Resident #2 stated Resident #1 pushed him. Resident #2 had a skin tear on his left forearm and left elbow. A record review of TULIP inidcated there was no facility-self report and 5th day report submitted by the facility During an interview on 01/13/25 at 8:45 a.m., the DON said she did not know the reason the incident between Resident #1 and Resident #2 was not reported. She said she was notified of the incident and notified the Administrator immediately. She said resident to resident abuse was reportable to the state. She said Resident #1 and Resident #2 were immediately separated with Resident #1 being moved to a different room. She said staff were trained prior to the incident and after the incident on abuse, neglect and reporting. During an interview on 01/13/25 at 9:00 a.m., the Administrator said he was the abuse coordinator. He said he did not report the incident between Resident #1 and Resident #2 as resident to resident abuse because it was two residents going back and forth and there was no serious injury. He said Resident #1 was moved immediately to another room. He said there was no history of incidents between Resident #1 or Resident #2. He said an allegation or incidents of abuse were reportable within 2 hours. He said the facility followed the facility policy and most recent provider letter regarding reporting abuse. He said residents were at risk of continued abuse if allegations of abuse were not reported as required. Record review of the facility's abuse policy, dated 02/01/17 (revised 01/27/20), indicated . The abuse coordinator with the Director of Nursing/designee will investigate all allegations and use the appropriate forms to document the investigation. And turn it into HHS within 5 calendar days

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25115 Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 17 residents (Resident #5) reviewed for care plans. The facility failed to ensure Resident #5's care plan ADL interventions were implemented on 09/22/24 resulting in serious injury. An Immediate Jeopardy (IJ) situation was identified on 01/23/25 at 3:23 p.m. While the IJ was removed on 01/24/25 at 6:37 p.m., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for staff not being aware of the resident needs and not receiving the care and services to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: Record review of Resident #5's face sheet indicated a [AGE] year old female, admitted to the facility on [DATE] (initially admitted on [DATE]). Resident #5 had diagnoses which included unspecified convulsions (seizures), displaced intertrochanteric fracture of left femur (thigh bone), dysphagia (swallowing difficulty), gastrostomy (feeding tube access), contracture of muscle (permanently shortened muscles), cervicalgia (neck pain), traumatic brain injury (usually results from a violent blow or jolt to the head or body), other abnormalities of gait and mobility (gait disorder), unilateral primary osteoarthritis of left hip (degenerative joint condition that primarily affects one side of the body), need for assistance with personal care, scoliosis (spine deformity) and muscle wasting and atrophy (loss of muscle mass). Record review of Resident #5's quarterly MDS assessment, dated 08/16/24, indicated she sometimes was able to make herself understood and understood others, she had severe cognitive impairment with a BIMS of 1, she had impairment on both sides of upper and lower extremities, and she 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) on staff for all ADLS. Resident #5 was always incontinent of bladder and bowel. Record review of Resident #5's quarterly MDS assessment, dated 12/26/24, indicated she sometimes was able to make herself understood and understood others, she had severe cognitive impairment with a BIMS of 1, she had impairment on both sides of upper and lower extremities, and she 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) on staff for all ADLS. Resident #5 was always incontinent of bladder and bowel. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's care plan, dated 02/27/18 revised 09/15/19, indicated she had an ADL performance deficit. Interventions indicated Resident #5 was totally dependent on 2 staff to provide bed bath, required extensive assist by 2 staff for bed mobility, and required total assistance by 2 staff for toileting. Record review of Resident #5's care guide, dated 01/13/25, indicated Resident #5 was totally dependent on 2 staff to provide bed baths, she required extensive assist by 2 staff to turn and reposition in bed as necessary and she required total assistance by 2 staff for toileting. Record review of Resident #5's progress note, dated 09/22/24 at 10:50 p.m., completed by the DON indicated Resident #5 rolled off the bed. Resident #5 was o.k. PRN pain medication administered. On-call notified and an order for left leg and hip x-ray was received. Record review of Resident #5's care record, for 09/22/24, indicated CNA C provided care without a second staff. Record review of progress note, dated 09/23/24 at 3:03 a.m., competed by LVN H, indicated CNA C informed LVN H she needed help with Resident #5 because she rolled out of the bed when CNA C was adjusting her in the bed at 10:50 p.m. on 09/22/24. Upon entering Resident #5's room, LVN H noted Resident #5 on the floor beside her bed. Resident #5 did not give a description. Resident #5 stated, My leg hurts. Resident had her hand resting on her left leg. LVN H did not see any impairment. LVN H, CNA C, LVN I and LVN J assisted Resident back to bed. Record review of Resident #5's x-ray, dated 09/24/24, indicated no acute fracture or dislocation. Record review of a progress note, dated 10/03/24 at 3:04 p.m., and completed by the DON, indicated PT G informed the DON of Resident #5 sometimes crying, she was not sure if Resident #5 was crying due to her roommate constantly hollering out or if it was due to her being in pain. The DON informed PT G that Resident #5 could tell staff when she was in pain. PT G agreed with the DON and that Resident #5 informed her she was hurting, and she was going to apply a cold pack to Resident #5's leg to see if it helped. PT G stated Resident #5 even told her (PT G) about the fall she had. The DON contacted NP F and order was given for repeat X-ray. Record review of Resident #5's x-ray, dated 10/03/24, of left hip indicated age indeterminate, transverse, comminuted, mildly displaced intertrochanteric fracture femur with varus deformity (hip fracture where the bone is broken across its width (transverse) in multiple pieces (comminuted) slightly shifted out of place (mildly displaced) and angled inwards at the fracture site creating a varus deformity typically seen in the area between the greater and lesser trochanters of the femur (the inter trochanteric region). Record review of hospital records, dated 10/07/24, indicated Resident #5 had surgical repair of left hip fracture. Record review of Resident #5's fall assessment ,dated 06/27/24, indicated she was a moderate fall risk. Record review of Resident #5's fall assessment, dated 09/23/24, indicated she was a high fall risk. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's Admit/Readmit Screener, dated 10/08/24, completed by LVN A, indicated Resident #5 was totally dependent for all ADLS. Record review of the facility investigation, dated 10/11/24, indicated the facility determined Resident #5 had a fall on 09/22/24 and the fractured hip was most likely to have occurred at that time. During an interview on 01/13/25 at 10:56 a.m., CNA C said she was providing toileting care to Resident #5 on 09/22/24. She said she rolled Resident #5 over to remove the soiled brief and Resident #5 rolled off the bed onto the floor. She said she always provided care to Resident #5 without a second staff. She said Resident #5 did not have hold of the side rail for repositioning. She said Resident #5 complained of pain to her left leg after she fell . She said she was trained to provide care for Resident #5 without a second staff. She could not recall who had trained her. She said she did not check Resident #5's care guide and had not seen the care guide which indicated Resident #5 required 2 staff for bed bath bed mobility, or toileting. She said residents were at risk of injury if they did not receive care as required. During an interview on 01/13/25 at 11:15 a.m., the DON said Resident #5 fell from the bed during care. She said she was assessed with no injury. She said Resident #5 required only 1 staff to provide care because Resident #5 could assist with turning and repositioning by holding on to the side rails. She said the care plan should say 1 person and not 2 persons for care. She said residents were at risk of injury if their care guide was not accurate or if staff did not follow the care guide. She said the care guide was dated 10/08/24 on Resident #5's readmission from hospital. During an interview on 01/13/25 at 11:36 a.m., MDS LVN E said Resident #5's MDS dated [DATE] and 12/26/24 were completed using the previous 7 days of documentation by staff. She said if there were two staff providing care one time in the previous 7 days then the MDS would indicate 2 staff were required. She said the care plan was based on the MDS. She said the care plan populated the resident care guide. She said the care plan was not revised to indicate 1 staff could provide Resident #5's care. She said she did not update Resident #1's care plan when she returned from the hospital. She said residents were at risk of injury if they did not receive care as required. During an interview on 01/14/25 at 9:20 a.m., CNA P said Resident #5's care guide indicated 2 staff were required for bed bath, bed mobility, and toileting. She said she would ask a second aide or nurse to assist if she was providing care when she (Resident #5) fell out of the bed. During an interview on 01/14/25 at 11:15 a.m., CNA ZZ said he provided Resident #5's care without a second staff. He said Resident #5 assisted with repositioning and turning during care by holding the side rail. He said she was never in distress or exhibited signs of pain when he provided care. He said he did not see she was 2-person assist on the care guide. He said he was trained to provide her care without a second staff. He said was able to access the care guide to determine the level of care a resident required. During an interview on 01/14/25 at 11:24 a.m., RN B said Resident #5 was normally a 1-person assist with care because she (Resident #5) could assist with repositioning and turning and would hold the side rail. She said she did not know why the care plan or care guide indicated 2 person assist. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/14/25 at 11:30 a.m., Resident #5 said no when asked if she had hold of the rail for repositioning when she fell off the bed. Resident #5 said yes when asked if only 1 staff provided care when she fell out of the bed and said yes when asked if usually 1 staff provided her care. During an interview on 01/15/25 at 9:48 a.m., LVN Q said she did not know why 1 staff would provide care for any resident if the care guide said 2 staff were required. She said she would assist any aide who requested assist with Resident #5. During an interview on 01/15/25 at 10:11 a.m., NP F said it was her opinion Resident #5 required 2 staff for care due to Resident #5's physical condition and being immobile in bed. During an interview on 01/15/25 at 1:30 p.m., CNA O said she would take care of Resident #5 without a second staff. She said she did not know Resident #2's care guide indicated she required 2 staff for care. She said she never noticed the indication for 2 staff. She was able to to access resident care guide but never noticed the required two staff. During an interview on 01/15/25 at 1:50 p.m., the DON said staff looked at the resident care guide to know how to care for residents. Staff should check the care guide to know if the residents' care was changed. Residents were at risk of potential harm or injury if 1 person did their care and 2 staff were required. During an interview on 01/23/25 at 12:00 p.m., the DON said on 09/22/24, Resident #5's care plan indicated she required 2 staff for bathing, repositioning and toileting. She said she was responsible for implementing interventions post incident. She said she would review the incident report and if interventions were decided on, she would get an order and implement the interventions. She said fall mats were implemented after Resident #5 fell out of her bed on 09/22/24. She said she did not evaluate the need for 2 staff for resident safety because CNA C reported she was walking past Resident #5's room and saw her leg hanging out of the bed. She said CNA C attempted to reposition Resident #5 and Resident #5 continued to roll out of the bed. During an interview on 01/23/25 at 12:35 p.m., CNA C said she did not remember exactly what happened on 09/22/24 when Resident #5 fell out of the bed. She said she assumed it was because she was changing Resident #5 but when asked about repositioning Resident #5's leg she said Resident #5 fell out of the bed when she pulled the draw sheet. She said she may have put Resident #5's leg up and checked her for wetness and that was when Resident #5 rolled out of the bed. Record review of the facility's Comprehensive Care Plan Policy, dated 01/20/21, indicated the resident will have an individualized interdisciplinary plan of care in place . The Care Plan is revised every quarter, significant change of condition, annual or as the resident condition changes on an individualized basis. The Care Plan process is an ongoing review process. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's Incident and Accident Policy, dated 03/01/17, indicated . 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; Ensuring that interventions are implemented; and documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring the interventions are implemented correctly and consistently. Record review of the facility's Safety and Supervision of Residents policy, dated 2001 (revised July 2017), indicated . 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. This was determined to be an Immediate Jeopardy (IJ) on 01/23/25 at 3:23 p.m. The facility's Administrator and DON were notified. The Administrator was provided the IJ template on 01/23/25 at 3:23 p.m. The following Plan of Removal (POR) submitted by the facility was accepted on 01/24/25 at 4:27 p.m.: Plan of Action Immediate action taken by staff: Physical Therapy evaluated Resident #5 to ensure appropriate staff assist to prevent further accidents. The Director of Clinical Operations implemented floor mats for Resident #5 on 9/22/2024. The MDS nurse updated the level of assist to 1-2 person for ADL's for Resident #5 to prevent further injuries on 1/13/2025. Physical Therapy determines the level of assistance required. The MDS Nurse implemented scoop mattress for Resident #5 to prevent further injuries on 1/24/2025. The above change in care is discussed in the morning clinical meeting with the update being added to the Kardex to keep staff informed. The MDS Nurse is responsible for making the update on a quarterly basis, or as needed if a change occurs, after the IDT has discussed the resident. The IDT determines the number of staff (increase/decrease) that is needed for ADL's. On 1/24/2025 at 3:30 pm the EDO had the therapist go re-evaluate Resident #5 for ADL care. The evaluation showed that Resident #5 was a 1 person assist for bed mobility. The IDT met and are in agreeance will make the change on the care plan effective 1/24/2025. The Director of Clinical Services will perform an in-service education to the staff immediately on the level of care during of this assessment of Resident #5. The MDS Nurse and/or designee will review fall care plans on all residents to ensure that they are appropriate and will help prevent injuries by ensuring the appropriate level of assistance needed for ADL's by team members. Completion date 1/24/2025 by 10:00am. All care plans will be reviewed to ensure the appropriate level of assistance for ADL's by staff is accurate by the MDS Nurse and/or designee. The care plan will update the Kardex to show the level of assistance needed to all nursing staff. Completion date 1/24/2025 by 10:00am. All incidents/accidents will be reviewed in the morning clinical meeting by the Director of Clinical of Operations and/or designee to ensure that care plan is updated to reflect any changes in level of care and appropriate interventions are in place after each fall. Completion date 1/24/2025 by 10:00am and ongoing. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-service Education will be provided to all nursing staff by the Director of Clinical Services and/or designee. Staff will not be allowed to work until in-service education has been provided which includes: 1. How to use the Kardex to determine the level of staff assistance needed to care for the residents. The change in level of assistance will be communicated in the morning clinical meeting and the Kardex is updated at that time. Completion Date of all in-service 1/24/2025 by 10:00am. The Director of Clinical Services and/or the Assistant Director of Clinical Services will randomly monitor two nurse aides weekly times 10 weeks to ensure that they are utilizing the Kardex for resident care. Any aide that is not utilizing the Kardex system will be re-trained immediately. Completion date 1/24/2025 at 12:00 pm and on-going. The Regional Clinical Reimbursement Coordinator will perform in-service education with the MDS Nurses on personalizing the care plan for falls with interventions and level of care provided by team members. The Director of Clinical Services and/or the Assistant Director of Clinical Services will monitor during the morning clinical meeting, during the review of incidents/accidents, that the interventions and level of care provided by team members are being reviewed and care plan changed as needed. Completion date 1/24/2025 by 10:00am. The incident/accident care plans will be monitored by the Director of Clinical Services and/or by the Assistant Director of Clinical Services in the morning clinical meeting with the IDT to ensure appropriate fall interventions are in place for the resident's care plan. The fall interventions will be monitored for 72 hours by the Director of Clinical Operation and/or designee to ensure that the intervention is effective. If the fall intervention is not effective the IDT will make other recommendations for a new approach and the care plan will be updated. Completion date by 1/24/2025 by 10:00am and ongoing. Monitoring of the Plan of Removal included the following: Observations conducted on 01/24/25 between 4:27 p.m. and 6:37 p.m. indicated staff (CNA W and CNA C) were able to access the Kardex (resident care guide) to determine level of staff require as required. Resident #5 had a scoop mattress, floor mats, low bed, and call light in reach. There were no observed concerns. Interviews with staff (DON, ADON DD, ADON EE, RN B, RN CC, MDS LVN E, LVN A, LVN H, LVN I, LVN J, LVN K, LVN L, CNA C, CNA M, CNA N, CNA O, CNA P, CNA W, CNA X, CNA Y, and CNA Z), who represented all shifts (6:00 a.m.-2:00 p.m., 2:00 p.m. -10:00 p.m., and 10:00 p.m.-6:00 a.m.) indicated they were aware of and able to give examples of how to use the Kardex/care guide (level of care required for ADLS included bed mobility, incontinent care/toileting, and bathing). Nursing staff indicated they observed and monitor staff every shift to ensure care was provided per each resident's care plan and care guide and would immediately intervene and retrain staff if necessary. During an interview on 01/24/25 at 5:22 p.m., MDS LVN E indicated she was responsible for making the care plan updates on a quarterly basis or as needed if a change occurred. She said the IDT determined the number of staff (increase/decrease) that were needed for ADLS. Record review of Resident #5's PT assessment dated [DATE] indicated she used both hands to help with rolling and only required 1 staff to provide safe hygiene, ADLS, bathing and repositioning. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's care plan indicated a scoop mattress was implemented as of 01/24/25 and she required 1 person staff assist for ADLS. Record review of incident and accident reports from 12/24/24 through 01/24/25, indicated care plans were appropriate and personalized for 7 of 7 residents (Residents #13, #14 #15, #16, #17, #18, #19) reviewed. Record review of Incidents and accident reports from 12/24/24 through 01/24/25, indicated there was adequate staff assistance as indicated in the care plan recommendations for 7 of 7 residents (Residents #13, #14 #15, #16, #17, #18, #19) reviewed. Record review of the facility's monitoring indicated the Director of Clinical Operation and/or designee reviewed incident/accident reports in the morning clinical meeting with the IDT to ensure appropriate interventions were in place for the resident. There were no concerns noted. Record review of incidents/accidents reviewed in the morning clinical meeting on 01/24/25 by the Director of Clinical Operations and/or designee indicated care plans were updated to reflect any changes in the level of care and appropriate interventions were in place. Record review of readmissions on 01/24/25 from the hospital indicated there was no re-admission to the facility. Record review of staff training dated 01/24/25 indicated staff training included how to use the Kardex/care guide to determine level of staff assistance needed to care for the residents, the change in level of assistance would be communicated in morning meeting and the resident Kardex/care guide updated during the morning meeting. Record review of staff training dated 01/24/25 indicated the MDS nurse was trained on personalizing resident care plans for falls with interventions and level of care required for ADLS. The Administrator was informed the Immediate Jeopardy was removed on 01/24/25 at 6:37 p.m. The facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems.

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Focused Care at Orange	4201 Fm 105 Orange, TX 77630

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 25115 Based on observation , interview and record review the facility failed to provide supervision and assistance devices to prevent accident for 1 of 17 (Resident #5) residents reviewed for accidents/supervision. The facility failed to ensure CNA C provided ADL care with 2 person assistance. Resident #5 fell out of her bed and sustained a fractured left femur during care on 09/22/24. An Immediate Jeopardy (IJ) situation was identified on 01/23/25 at 3:23 p.m. While the IJ was removed on 01/24/25 at 6:37 p.m., the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of accidents and injuries. Findings include: Record review of Resident #5's face sheet indicated a [AGE] year old female, admitted to the facility on [DATE] (initially admitted on [DATE]). Resident #5 had diagnoses which included unspecified convulsions (seizures), displaced intertrochanteric fracture of left femur (thigh bone), dysphagia (swallowing difficulty), gastrostomy (feeding tube access), contracture of muscle (permanently shortened muscles), cervicalgia (neck pain), traumatic brain injury (usually results from a violent blow or jolt to the head or body), other abnormalities of gait and mobility (gait disorder), unilateral primary osteoarthritis of left hip (degenerative joint condition that primarily affects one side of the body), need for assistance with personal care, scoliosis (spine deformity) and muscle wasting and atrophy (loss of muscle mass). Record review of Resident #5's quarterly MDS assessment, dated 08/16/24, indicated she sometimes was able to make herself understood and understood others, she had severe cognitive impairment with a BIMS of 1, she had impairment on both sides of upper and lower extremities, and she 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) on staff for all ADLS. Resident #5 was always incontinent of bladder and bowel. Record review of Resident #5's quarterly MDS assessment, dated 12/26/24, indicated she sometimes was able to make herself understood and understood others, she had severe cognitive impairment with a BIMS of 1, she had impairment on both sides of upper and lower extremities, and she 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) on staff for all ADLS. Resident #5 was always incontinent of bladder and bowel. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's care plan, dated 02/27/18 revised 09/15/19, indicated she had an ADL performance deficit. Interventions indicated Resident #5 was totally dependent on 2 staff to provide bed bath, required extensive assist by 2 staff for bed mobility, and required total assistance by 2 staff for toileting. Record review of Resident #5's care guide, dated 01/13/25, indicated Resident #5 was totally dependent on 2 staff to provide bed baths, she required extensive assist by 2 staff to turn and reposition in bed as necessary and she required total assistance by 2 staff for toileting. Record review of Resident #5's progress note, dated 09/22/24 at 10:50 p.m., completed by the DON indicated Resident #5 rolled off the bed. Resident #5 was o.k. PRN pain medication administered. On-call notified and an order for left leg and hip x-ray was received. Record review of Resident #5's care record, for 09/22/24, indicated CNA C provided care without a second staff. Record review of progress note, dated 09/23/24 at 3:03 a.m., competed by LVN H, indicated CNA C informed LVN H she needed help with Resident #5 because she rolled out of the bed when CNA C was adjusting her in the bed at 10:50 p.m. on 09/22/24. Upon entering Resident #5's room, LVN H noted Resident #5 on the floor beside her bed. Resident #5 did not give a description. Resident #5 stated, My leg hurts. Resident had her hand resting on her left leg. LVN H did not see any impairment. LVN H, CNA C, LVN I and LVN J assisted Resident back to bed. Record review of Resident #5's x-ray, dated 09/24/24, indicated no acute fracture or dislocation. Record review of a progress note, dated 10/03/24 at 3:04 p.m., and completed by the DON, indicated PT G informed the DON of Resident #5 sometimes crying, she was not sure if Resident #5 was crying due to her roommate constantly hollering out or if it was due to her being in pain. The DON informed PT G that Resident #5 could tell staff when she was in pain. PT G agreed with the DON and that Resident #5 informed her she was hurting, and she was going to apply a cold pack to Resident #5's leg to see if it helped. PT G stated Resident #5 even told her (PT G) about the fall she had. The DON contacted NP F and order was given for repeat X-ray. Record review of Resident #5's x-ray, dated 10/03/24, of left hip indicated age indeterminate, transverse, comminuted, mildly displaced intertrochanteric fracture femur with varus deformity (hip fracture where the bone is broken across its width (transverse) in multiple pieces (comminuted) slightly shifted out of place (mildly displaced) and angled inwards at the fracture site creating a varus deformity typically seen in the area between the greater and lesser trochanters of the femur (the inter trochanteric region). Record review of hospital records, dated 10/07/24, indicated Resident #5 had surgical repair of left hip fracture. Record review of Resident #5's fall assessment, dated 06/27/24, indicated she was a moderate fall risk. Record review of Resident #5's fall assessment, dated 09/23/24, indicated she was a high fall risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's Admit/Readmit Screener, dated 10/08/24, completed by LVN A, indicated Resident #5 was totally dependent for all ADLS. Record review of the facility investigation, dated 10/11/24, indicated the facility determined Resident #5 had a fall on 09/22/24 and the fractured hip was most likely to have occurred at that time. During an interview on 01/13/25 at 10:56 a.m., CNA C said she was providing toileting care to Resident #5 on 09/22/24. She said she rolled Resident #5 over to remove the soiled brief and Resident #5 rolled off the bed onto the floor. She said she usually provided care to Resident #5 without a second staff because she was trained to provide care to Resident #5 without a second staff. She said Resident #5 did not have hold of the side rail for repositioning. She said Resident #5 would usually hold the side rail and assist with repositioning. She said an unnamed nurse assessed Resident #5 with no injuries then the nurse and other aides picked Resident #5 up and put her back in bed. She said Resident #5 complained of pain to her left leg. She said she was trained to provide care for Resident #5 without a second staff. She could not recall who trained her. She said she did not check Resident #5's care guide and did not realize the care guide indicated Resident #5 required 2 staff for bed bath bed mobility, or toileting. She said if she needed a second staff, she would ask an aide or a nurse for assistance. She said she was not aware of Resident #5 having any history of falling from the bed during care. She said residents were at risk of injury if they did not receive care as required. During an interview on 01/13/25 at 11:15 a.m., the DON stated Resident #5 fell from the bed during care. She said she was assessed with no injury. She said the physician was notified and ordered an x-ray of the left hip and leg. She said the first x-ray completed on 09/24/24 indicated no injury. She said on 10/03/24, PT G notified her (the DON) of Resident #5 being in pain during therapy. She said she notified the physician and N/O were obtained for a repeat x-ray. She said the x-ray completed on 10/3/24 indicated Resident #5 had a fractured left femur. She said Resident #5 was sent to the hospital for further evaluation and treatment. She said Resident #5 had surgical repair of her left hip. She said it was likely caused from the fall on 09/22/24 since there was no other identified cause of the fracture. She said Resident #5 required only 1 staff to provide care because Resident #5 could assist with turning and repositioning by holding on to the side rails. She said Resident #5 did not have any history of falling from the bed during care. She said residents were at risk of injury if their care guide was not accurate or if staff did not follow the care guide, or if they did not receive care as required. During an interview on 01/13/25 at 11:36 a.m., MDS LVN E said Resident #5's, MDS dated [DATE] and 12/26/24, were completed using the previous 7 days of documentation by staff. She said if there were two staff providing care one time in the previous 7 days then the MDS would indicate 2 staff were required. She said the care plan was based on the MDS. She said the care plan populated the resident care guide. She said the care plan was not revised to indicate 1 staff could provide Resident #5's care. She said residents were at risk of serious injury if they did not receive care as required. During an interview on 01/14/25 at 9:20 a.m., CNA P said Resident #5's care guide indicated 2 staff were required for bed bath, bed mobility, and toileting. She said she would ask a second aide or nurse to assist if she was providing care when she fell out of the bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/14/25 at 11:15 a.m., CNA ZZ said he provided Resident #5's care without a second staff because he was trained to provide care without a second staff. He said he could not recall who trained him to provide Resident #5's care. He said Resident #5 assisted with repositioning and turning during care by holding the side rail. He said she was never in distress or exhibited signs of pain when he provided care. He said he did not see she was 2-person assist on the care guide. He said he was trained to provide her care without a second staff. During an interview on 01/14/25 at 11:24 a.m., RN B said Resident #5 was normally a 1-person assist with care because she (Resident #5) could assist with repositioning and turning and would hold the side rail. She said she did not know why the care plan or care guide indicated 2 person assist. During an interview on 01/14/25 at 11:30 a.m., Resident #5 said no when asked if she had hold of the rail for repositioning when she fell off the bed. Resident #5 said yes when asked if only 1 staff provided care when she fell out of the bed and said yes when asked if usually 1 staff provided her care. She did not respond when asked who was the staff who provided care. She said yes when asked if her left leg hurt after the fall. During an interview on 01/14/25 at 1:55 p.m., PT G said it was her opinion 1 staff could provide Resident #5's care if Resident #5 was in the correct position and had hold of the side rail. She said Resident #5 sometimes could move her arm and her hand would grab the bed rail but sometimes the staff would have to move her arm and place her hand on the rail. She said she screened Resident #5 after her fall on 09/22/24 and was informed there was no fracture. She said she instructed the unnamed CNAs to be aware of Resident #5's position before rolling her in the bed. She said she attempted therapy on 10/03/24 with Resident #5 but Resident #5 was in pain and crying. During an interview on 01/15/25 at 9:48 a.m., RN B said she did not know why 1 staff would provide care for any resident if the care guide said 2 staff were required. She said she would assist any aide who requested assist with Resident #5. During an interview on 01/15/25 at 10:11 a.m., NP F said it was her opinion Resident #5 required 2 staff for care due to Resident #5's physical condition and being immobile in bed. She said it was probable the fractured femur occurred when Resident #5 fell from her bed on 09/22/24 but did not show in the first x-ray. She said the fractured femur became pronounced and visible on the second x-ray due to normal ADLS and physical therapy. During an interview on 01/15/25 at 1:30 p.m., CNA O said she would take care of Resident #5 without a second staff. She said she was trained to take care of her with 1 staff. She said Resident #5 would hold the side rail to assist with turning and repositioning. She said if she needed a second staff, she would ask an aide or a nurse for assistance. She said she did not realize Resident #2's care guide indicated she required 2 staff for care. She said she was not aware of Resident #5 having any history of falling from the bed during care. During an interview on 01/15/25 at 1:50 p.m., the DON said staff look at the resident care guide to know how to care for residents. Staff should check the care guide to know if the residents' care was changed. Residents were at risk of potential harm or injury if 1 person did their care and 2 staff were required. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/23/25 at 10:18 a.m., PT G said residents dependent for care or required 2 staff for ADLS did not always mean the resident was supposed to have 2 staff at all times. She said having two staff would make completing ADLS easier and require less time. She said staff would have to ensure the resident was in the correct position and centered in the bed at all times to ensure the resident was safe and not in danger of falling out of the bed during ADLS or repositioning. During an interview on 01/23/25 at 12:00 p.m., the DON said on 09/22/24, Resident #2's care plan indicated she required 2 staff for bathing, repositioning and toileting. She said she was responsible for implementing interventions post incident. She said she would review the incident report and if interventions were decided on, she would get an order and implement the interventions. She said fall mats were implemented after Resident #5 fell out of her bed on 09/22/24. She said she did not evaluate the need for 2 staff for resident safety because CNA C reported she was walking past Resident #5's room and saw her leg hanging out of the bed. She said CNA C attempted to reposition Resident #5 and Resident 5 continued to roll out of the bed. During an interview on 01/23/25 at 12:35 p.m., CNA C said she did not remember exactly what happened on 09/22/24 when Resident #5 fell out of the bed. She said she assumed it was because she was changing Resident #5 but when asked about repositioning Resident #5's leg she said Resident #5 fell out of the bed when she pulled the draw sheet. She said she may have put Resident #5's leg up and checked her for wetness and that was when Resident #5 rolled out of the bed. Record review of the facility's Incident and Accident Policy, dated 03/01/17, indicated Our facility strives to make the environment as free from hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; Ensuring that interventions are implemented; and documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring the interventions are implemented correctly and consistently. Record review of the facility's Safety and Supervision of Residents policy, dated 2001 (revised July 2017), indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . 1. Our individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. This was determined to be an Immediate Jeopardy (IJ) on 01/23/25 at 3:23 p.m. The facility's Administrator and DON were notified. The Administrator was provided with the IJ template on 01/23/25 at 3:23 p.m. The following Plan of Removal (POR) submitted by the facility was accepted on 01/24/25 at 4:27 p.m.: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Plan of Action Immediate action taken by staff: The nurse entered the room after being notified by aide that Resident #5 was on the floor beside her bed. The resident was assessed by the nurse and assisted back to bed with four staff members. The resident complained of pain to the left leg. The nurse did not see any impairment at this time. The nurse administered pain medication, notified attending physician, and family of fall. Attending physician ordered X-ray to the left hip and left leg. The nurse left the room with the bed in low position and call light within reach. X-ray results showed no fracture. The nurse will continue to assess and monitor for pain. Physical Therapy evaluated Resident #5 to ensure appropriate staff assist to prevent further accidents. The Director of Clinical Operations implemented floor mats for Resident #5 on 9/22/2024. The MDS Nurse implemented scoop mattress for Resident #5 to prevent further injuries on 1/24/2025. The above change in care are discussed in the morning clinical meeting with the update being added to the Kardex to keep staff informed. The MDS Nurse is responsible for making the update on a quarterly basis, or as needed if a change occurs, after the IDT has discussed the resident. The IDT determines the number of staff (increase/decrease) that is needed for ADL's. On 1/24/2025 at 3:30 pm the EDO had the therapist go re-evaluate Resident #5 for ADL care. The evaluation showed that Resident #5 was a 1 person assist for bed mobility. The IDT met and are in agreeance will make the change on the care plan effective 1/24/2025. The Director of Clinical Services will perform an in-service education to the staff immediately on the level of care during of this assessment of Resident #5. The Director of Clinical Operations and/or the Assistant Director of Clinical Operations will review incidents and accidents within the last 30 days with a focus on falls to ensure care plans were appropriate and personalized with interventions after each fall. Completion date 1/24/2025 by 10:00am. The Director of Clinical Operations and/or designee will review incident/accidents reports in the morning clinical meeting to ensure that there was adequate staff assistance as indicated in the care plan recommendations. Completion date 1/24/2025 by 10:00am and ongoing. The Director of Clinical Operation and/or designee will review incident/accident reports in the morning clinical meeting with IDT to ensure appropriate intervention in place for the resident. The intervention will be monitored for 72 hours by the Director of Clinical Operation and/or designee to ensure that the intervention is effective. If the intervention is not effective the IDT will make other recommendations for a new approach. Completion date 1/24/2025 by 10:00am. Morse fall risk assessments were reviewed on all residents by the Director of Clinical Operations and/or the Assistant Director of Clinical Operations. Residents identified as having a high fall risk will have care plans and Kardex updated with interventions and reflect any changes to their personalized plan of care. Completion date 1/24/2025 by 10:00am. All incidents/accidents will be reviewed in the morning clinical meeting by the Director of Clinical Operations and/or designee to ensure that care plan is updated to reflect any changes in level of care and appropriate interventions are in place. Completion date 1/24/2025 by 10:00am and ongoing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All readmissions from the hospital will be reviewed in the morning clinical meeting by the Director of Clinical Operations and Assistant Director of Clinical Operations for any changes in the level of care. The care plan will be updated for any noted changes in the level of care. Completion date 1/24/2025 by 10:00am and ongoing. In-service Education will be provided to all nursing staff by the Director of Clinical Services and/or designee. Staff will not be allowed to work until in-service education has been provided which includes: 1. Fall interventions (referral to therapy, fall mats, low bed, change in level of assistance, etc.) and prevention of falls. 2. Appropriate interventions based on the resident's individualized assessment that are added to care plan after each fall. 3. How to use the Kardex to determine fall interventions put in place to ensure interventions are followed. Completion Date of all in-service 1/24/2025 by 10:00am. The Director of Clinical Services and/or the Assistant Director of Clinical Services will randomly monitor two nurse aides' weekly times 10 weeks to ensure that they are utilizing the Kardex for resident care. Any aide that is not utilizing the Kardex system will be re-trained immediately. Completion date 1/24/2025 at 10:00am and on-going. The Regional Director of Clinical Operations performed in-service education with DCO and ADCO's on personalizing of interventions put into place to prevent falls. Completion date 1/24/2025 by 10:00am. The Director of Clinical Services and/or Assistant Director of Nursing will refer any resident that exhibits pain or injury related to a fall to be screen/evaluated by physical therapy for changes in ADL care. The care plan will be updated with therapy recommendations. Completion Date on 1/24/2025 at 10:00am and ongoing. Monitoring of the Plan of Removal included the following: Observations conducted on 01/24/25 between 4:27 p.m. and 6:37 p.m. indicated staff were able to access the Kardex (resident care guide) to determine the level of staff require as required. There were no observed concerns. Observation conducted on 01/24/25 at 5:00 p.m. indicated Resident #5 laid on a scoop mattress. Her bed was in the low position and the fall mats were on each side of her bed. There were no observed concerns. Interviews on 01/24/25 from 4:27 p.m. through 6:35 p.m. with staff (DON, ADON DD, ADON EE, RN B, RN CC, MDS LVN E, LVN A, LVN H, LVN I, LVN J, LVN K, LVN L, CNA C, CNA M, CNA N, CNA O, CNA P, CNA W, CNA X, CNA Y, and CNA Z), who represented all shifts (6:00 a.m.-2:00 p.m., 2:00 p.m. -10:00 p.m., and 10:00 p.m.-6:00 a.m.) indicated they were aware of and able to give examples of how to use the Kardex/care guide (level of care required for ADLS included bed mobility, incontinent care/toileting, and bathing). Staff were aware of Resident #5's level of assistance needs. Nursing staff indicated they observed and monitor staff every shift to ensure care was provided per each resident's care plan and care guide and would immediately intervene and retrain staff if necessary. During an interview on 01/24/25 at 5:22 p.m., MDS LVN E indicated she was responsible for making the care plan updates on a quarterly basis or as needed if a change occurred. She said the IDT determined the number of staff (increase/decrease) that were needed for ADLS. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #5's PT assessment dated [DATE] indicated she used both hands to help with rolling and only required 1 staff to provide safe hygiene, ADLS, bathing and repositioning. Record review of Resident #5's care plan indicated a scoop mattress was implemented as of 01/24/25 and she required 1 person staff assist for ADLS. Record review of incident and accident reports from 12/24/24 through 01/24/25 indicated care plans were appropriate and personalized for 7 of 7 residents(Residents #13, #14 #15, #16, #17, #18, #19) reviewed. Record review of Incidents and accident reports from 12/24/24 through 01/24/25 indicated there was adequate staff assistance as indicated in the care plan recommendations for 7 of 7 residents (Residents #13, #14 #15, #16, #17, #18, #19) reviewed. Record review of the facility monitoring date 01/24/25 indicated the Director of Clinical Operation and/or designee reviewed incident/accident reports in the morning clinical meeting with the IDT to ensure appropriate intervention in place for the resident. There was no concerns noted. Record review of residents' Morse fall risk assessments reviewed on 01/24/25on all residents by the Director of Clinical Operations and/or the Assistant Director of Clinical Operations. 7 of 7 residents (Resident #3, #13, #14, #15, #19, #20, and #21) identified as high fall risk care plans and Kardex were updated with interventions and reflected any changes to their personalized plan of care. Record review of incidents/accidents reviewed in the morning clinical meeting on 01/24/25 by the Director of Clinical Operations and/or designee indicated care plans were updated to reflect any changes in the level of care and appropriate interventions were in place. Record review of readmissions on 01/24/25 from the hospital indicated there was no re-admission to the facility. Record review of staff training dated 01/24/25 indicated staff training included: 1. Fall interventions (referral to therapy, fall mats, low bed, change in level of assistance, etc.) and prevention of falls. 2. Appropriate interventions based on the resident's individualized assessment that are added to care plan after each fall. 3. How to use the Kardex to determine fall interventions put in place to ensure interventions are followed. Record review of staff training dated 01/24/25 indicated the DCO and ADCO's were trained on personalizing of interventions put into place to prevent falls. The Administrator was informed the Immediate Jeopardy was removed on 01/24/25 at 6:37 p.m. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.