STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676119	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47573 Based on observations, interviews, and record review, the facility failed to accurately assess the resident's status for 1 of 5 residents (Resident #1) reviewed for accuracy of assessments. The facility failed to ensure Resident #1's fall risk evaluation on 10/04/24, baseline care plan on 10/04/24 and the MDS assessment on 10/14/24 accurately reflected her risk of falls. This failure could place residents at risk for not receiving care and services to meet their needs. The findings included: Record review of Resident #1's face sheet dated 10/30/24 reflected an [AGE] year-old female with an original admitted [DATE]. Her diagnoseis included: unspecified dementia, type 2 diabetes, heart disease, anemia, depression, mood disorder, anxiety disorder, insomnia, chronic obstructive pulmonary disease, and osteoarthritis (degenerative joint disease). (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 10/30/24 reflected Problem: [Resident #1] was at risk for falls related to confusion, gait/balance problems, unaware of safety needs, and attempts to ambulate without assistance. Date initiated: 10/06/24. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Electrical bed at lowest position. Provide resident with mobility device: wheelchair. Therapy evaluate and treat as ordered or PRN. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/team as to causes. Date initiated: 10/06/24. May have floor matt on side of bed. Date initiated: 10/30/24. Activities tray trial. Date initiated: 10/30/24. Problem: [Resident #1] had an actual fall related to poor balance, psychoactive drug use, and unsteady gait. Interventions: toileting after meals. Date initiated: 10/05/24. Raised perimeter mattress. Continue interventions on the at-risk plan. For no apparent acute injury, determine and address causative factors of the fall. May have floor mat on side of bed. Neurological checks. Therapy consult for strength and mobility. Monitor/document /report PRN x 72h to MD for signs/symptoms: pain, bruises, change in mental status or new onset: confusion, sleepiness, inability to maintain posture, or agitation. Date initiated: 10/06/24. Activities referral. Date initiated: 10/15/24. Antibiotics. Date initiated: 10/27/24. Problem: [Resident #1] had a scalp laceration related to a fall and was at risk for infection. Date initiated: 10/30/24. Interventions: Cleanse staples to scalp with wound cleanser, pat dry with 4x4 gauze one time a day for, and as needed for laceration. Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size, and treatment of skin tear. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD. Wound treatment as ordered. Date initiated: 10/30/24 . Record review of Resident #1's baseline care plan dated 10/04/24 reflected Resident #1 was not at risk for falls. Record review of Resident #1's fall risk evaluation dated 10/04/24 reflected Resident #1 did not have any falls in the past 3 months. The fall risk evaluation had a score of 5 which was low risk. Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 5 (severe cognitive impairment). Resident #1 required substantial/maximal assistance (helper does more than half the effort) for rolling left/right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and toilet transfer. Fall history on admission indicated that Resident #1 did not have a fall any time in the last month and 2-6 months prior to admission . Interview with FM 1 on 10/30/24 at 12:00 PM revealed FM 1 was concerned that Resident #1 did not have enough supervision and had fallen 5 times. FM 1 said the facility had implemented some interventions, but she did not believe it had been enough. FM 1 said the facility staff did not check on Resident #1 frequently. FM 1 said Resident #1 did not understand that she could no longer walk on her own and if left unsupervised, Resident #1 tried to get up and walk. Interview with Resident #1 on 10/30/24 at 2:40 PM revealed Resident #1 did not provide any relevant information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #1 on 10/30/24 at 2:40 PM revealed Resident #1 appeared with good personal hygiene and not in distress. Fall mat was in the room but moved to the side as the resident was up into her wheelchair. Resident #1 had a perimeter raised mattress. Resident #1 was sitting on the wheelchair and fell asleep. Resident #1 had a tray and footrests on her wheelchair. Resident #1 had a laceration to the left/top side of her head about 1.5 inches long with 3 staples. No hematoma or bruising noted. Resident #1 remained asleep and did not slouch or move to the sides. Interview with RN E on 10/31/24 at 12:15 PM revealed RN E said she completed the admission for Resident #1. RN E said she completed the admission assessments including the fall risk evaluation. RN E said the fall risk score and whether or not the resident was considered at risk for falls was based on the questions asked. RN E said during the admission, FM 2 was present with Resident #1 and FM 2 mentioned that Resident #1 had fallen at home. RN E said FM 2 said that Resident #1 got up without telling anyone and by the time FM 2 saw Resident #1, she had fallen. RN E said she did not ask FM 2 follow up questions such as how long ago Resident #1 had fallen, when was the last time, how she fell , or how many falls she had. RN E said when a resident was admitted from the hospital, RN E reviewed hospital records for more information. RN E said Resident #1 was admitted from home and RN E could have asked FM 2 more questions regarding Resident #1's falls, but RN E did not. RN E said she had other questions to ask FM 2 for the admission and did not ask FM 2 more about the falls. RN E said it was important to accurately complete the assessments to know what assistance the resident required and to inform the staff on how to care for the resident. Interview with MDS N on 10/31/24 at 1:30 PM revealed MDS N said he completed assessments quarterly and updated the care plans. MDS N said during the admission, the nurse completed the assessments which asked about falls. MDS N said the nurse could have gotten that information from records or asked the family. MDS N said the nurse could have asked for more details of the falls if the family was present. MDS N said it was important to obtain the correct information and implement interventions on their care plan to provide person centered care and to avoid injuries. MDS N said if the resident was at risk for falls, then the interventions were meant to prevent falls, and if interventions were not implemented appropriately, then the resident would have been at risk of falls or injuries. MDS N said if Resident #1 had been noted to be at risk for falls during her admission, then the interventions implemented could have been frequent rounds, encourage the resident to attend activities, fall mat, call light within reach, oriented to the call light, etc. depending on the assessment. MDS N said ADON P worked on incidents such as falls and implemented interventions based on each fall . Interview with FM 2 on 11/04/24 at 10:30 AM revealed FM 2 was present during Resident #1's admission process on 10/04/24. FM 2 said she told the nurse that Resident #1 was at risk for falls. FM 2 said Resident #1 had falls June 2023 and October 2023. FM 2 said in January 2024, the specialist saw Resident #1 and decided Resident #1 should no longer use the walker as Resident #1's mind was not connecting to her legs anymore. FM 2 said Resident #1 continued to try to get up at home, but FM 2 redirected her and tried her best to prevent falls. FM 2 said most of the time when Resident #1 tried to get up was because she needed to go to the restroom. FM 2 said the falls Resident #1 had last year were at night and because she needed to go to the restroom. FM 2 said she did not remember the nurse that completed the admission, but the nurse did not ask FM 2 about why Resident #1 fell , when she fell , or more information about the falls. FM 2 said the nurse did not ask when the last time was Resident #1 fell or how many falls she had. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with ADON P on 11/04/24 at 11:45 AM revealed ADON P reviewed falls and implemented interventions based on the investigation of the incident or the reason for the fall. ADON P said FM 2 informed them of Resident #1 falling at home in the past, so they implemented the electrical bed to its lowest position that first night of admission on 10/04/24. ADON P said the risk for falls was added to the care plan on 10/06/24 after she had fallen on 10/05/24 and 10/06/24 as it was the weekend. ADON P said the baseline care plan had been completed during admission on 10/04/24. ADON P said Resident #1 was admitted from home so the nurse would have gotten the information and history from the family. ADON P said the nurse should have asked questions like when Resident #1 fell , were there any fractures/injuries, and did she follow up with the doctor. ADON P said if Resident #1 had the baseline care plan trigger the fall risk from the day of admission, that could have prevented her falls, but they were not familiar with her behaviors. ADON P said they did not know what kind of falls Resident #1 would have had. ADON P said once FM 2 came in more frequent, then FM 2 let them know what kind of behaviors Resident #1 had at home . Interview with the DON on 11/04/24 at 1:00 PM revealed the DON said Resident #1 was not assessed accurately on 10/04/24 during the admissions process as the fall risk evaluation indicated Resident #1 was not at risk for falls. The DON said she discussed the assessment with RN E and RN E said she did not know why she indicated Resident #1 was not at fall risk. The DON said Resident #1 was at risk for falls since admission. The DON said she did not think if the fall risk was triggered since the baseline care plan, that it would have made a difference in preventing Resident #1 from falling. The DON said if the family had mentioned to RN E that Resident #1 had falls in the past, the nurse should have asked follow-up questions like when the last fall was, how many falls has she had, etc. The DON said she believed there was enough supervision, but they just did not know Resident #1 well enough to implement interventions sooner for falls . Interview with the ADM on 11/04/24 at 2:20 PM revealed the ADM said they discussed as a team for falls and interventions, but ultimately the clinical department, DON/ADON, decided and implemented interventions. The ADM said it was important to care plan interventions appropriately to know how to care for the resident. The ADM said if during the initial assessment, Resident #1 had been identified as a fall risk, then the nurse who completed the initial assessment, should have asked more questions, and gathered more details if the family mentioned Resident #1 had fallen before. Record review of the Fall Prevention Program date implemented: 08/15/22 reflected: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. Record review of the Baseline Care Plan Policy date implemented: 10/22/22 reflected: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. (continued on next page)

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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** 47573 Based on interviews and record review the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents and supervision. The facility failed to ensure Resident #1 received adequate supervision to prevent accidents as Resident #1 was left unsupervised in the dining room and fell on [DATE], sustaining a 2.5 cm laceration with 3 staples. This failure could place residents at risk of injury and a decreased quality of life. The findings included: Record review of Resident #1's face sheet dated 10/30/24 reflected an [AGE] year-old female with an original admitted [DATE]. Her diagnosis included: unspecified dementia, type 2 diabetes, heart disease, anemia, depression, mood disorder, anxiety disorder, insomnia, chronic obstructive pulmonary disease, and osteoarthritis (degenerative joint disease). Record review of Resident #1's care plan dated 10/30/24 reflected Problem: [Resident #1] was at risk for falls related to confusion, gait/balance problems, unaware of safety needs, and attempts to ambulate without assistance. Date initiated: 10/06/24. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Electrical bed at lowest position. Provide resident with mobility device: wheelchair. Therapy evaluate and treat as ordered or PRN. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/team as to causes. Date initiated: 10/06/24. May have floor matt on side of bed. Date initiated: 10/30/24. Activities tray trial. Date initiated: 10/30/24. Problem: [Resident #1] had an actual fall related to poor balance, psychoactive drug use, and unsteady gait. Interventions: toileting after meals. Date initiated: 10/05/24. Raised perimeter mattress. Continue interventions on the at-risk plan. For no apparent acute injury, determine and address causative factors of the fall. May have floor mat on side of bed. Neurological checks. Therapy consult for strength and mobility. Monitor/document /report PRN x 72h to MD for signs/symptoms: pain, bruises, change in mental status or new onset: confusion, sleepiness, inability to maintain posture, or agitation. Date initiated: 10/06/24. Activities referral. Date initiated: 10/15/24. Antibiotics. Date initiated: 10/27/24. Problem: [Resident #1] had a scalp laceration related to a fall and was at risk for infection. Date initiated: 10/30/24. Interventions: Cleanse staples to scalp with wound cleanser, pat dry with 4x4 gauze one time a day for and as needed for laceration. Encourage good nutrition and hydration in order to promote healthier skin. Monitor/document location, size and treatment of skin tear. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to MD. Wound treatment as ordered. Date initiated: 10/30/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's MDS assessment dated [DATE] reflected Resident #1 had a BIMS score of 5 (severe cognitive impairment). Resident #1 required substantial/maximal assistance (helper does more than half the effort) for rolling left/right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed transfer, and toilet transfer. Fall history on admission indicated that Resident #1 did not have a fall any time in the last month and 2-6 months prior to admission. Record review of Resident #1's incident report dated 10/05/24 at 12:30 PM reflected resident was sitting in the hallway with other residents after lunch. Resident attempted to get up from wheelchair on her own. Resident sustained an unwitnessed fall. Resident was noted on floor sitting down next to the wheelchair. No open wounds or injuries noted. Pain medication administered PRN. Neuro checks initiated. MD/RP made aware. Investigation: Resident complained of stomach pain. Resident had history of GI issues. Intervention: Resident to be offered toileting after meals. Record review of Resident #1's incident report dated 10/06/24 at 6:45 AM reflected resident fell in room while getting up from bed unassisted. Resident stated she was trying to go to the restroom. Upon assessment, pain noted to bilateral hips when attempting to extend legs to assess for visual deformity. No bruising or open wound noted to head. Resident stated she did not feel well but unable to verbalize what she felt except for pain to hips and stomach. Neuro checks initiated. RP aware. PA notified. New order to transfer resident to the hospital for evaluation. Investigation: As per RP, camera footage showed resident attempted to get up two times. First time, she got up and fell down on bed hitting head on headboard. Second time, she got up and landed on floor. As per resident, she wanted to go to the restroom. Resident with cognitive impairment due to dementia. Resident sent to ER for evaluation. No fractures as per x-rays. Intervention: raised perimeter mattress while in bed. Record review of Resident #1's incident report dated 10/15/24 at 4:30 PM reflected a CNA reported to the nurse that the resident was found on the floor of the 400 hallway, lying on the floor in which she appeared to have fallen from her wheelchair in an attempt to stand up on her own. Resident was assessed for any injuries and skin impairments in which resident reported pain to the left shoulder. Neuro checks initiated. MD/RP made aware. Investigation: X-rays to left shoulder ordered due to pain. No fractures noted. Intervention: activities referral. Record review of Resident #1's incident report dated 10/16/24 at 3:15 AM reflected the nurse was informed by a CNA that the resident was found on the floor in her room upon entering room. Resident was sitting on the floor with her legs extended. Resident was no table to voice what happened due to her dementia. Nurse performed head to toe assessment with no apparent injuries noted. RP/ADON/PA made aware. Fall precautions in place: bed at lowest position, call light within reach, frequent intervals offer toileting needs, and continue to make rounds every 15 minutes. Neuro checks initiated. Investigation: Resident sustained a fall from bed attempting to ambulate. Intervention: may have floor mat on side of bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's incident report dated 10/27/24 at 10:15 AM reflected the nurse was in the nurse's station when she was called by housekeeping staff who stated resident was lying on the floor in the dining area. Nurse immediately went to assess resident. Resident was laying on the floor on her back with head under dining room table and feet to resident's wheelchair. Resident was wearing proper footwear at time of incident. Nurse notified 400 hall charge nurse and resident was assessed for injuries. A laceration was noted to left side of back of head with active bleeding. Resident was applied pressure to area with 4 x 4 gauze. No other injuries were noted. Resident does not recall what she wanted to do when she got up from her wheelchair, but she just recalled falling and hitting her head on the chair handle. Resident complained of pain to head and lower back. RP notified. PA notified. Order to send out resident to the hospital for further evaluation and treatment. Nurse called the hospital and gave report to ER nurse. Investigation: Resident sustained fall from wheelchair. Resident with laceration to left side of back of head. Sent to ER. X-rays were negative for fractures. Positive for UTI. Resident started on antibiotics. Intervention: antibiotics. Record review of Resident #1's skin and wound assessment dated [DATE] reflected the laceration to the head measuring 2.5 cm (length), 0.7 cm (width), and 0.2 cm (depth). Cleanse laceration daily. Interview with FM 1 on 10/30/24 at 12:00 PM revealed FM 1 was concerned that Resident #1 did not have enough supervision and had fallen 5 times. FM 1 said the facility had implemented some interventions, but she did not believe it had been enough. FM 1 said the facility staff did not check on Resident #1 frequently. FM 1 said Resident #1 did not understand that she could no longer walk on her own and if left unsupervised, Resident #1 tried to get up and walk. Interview with Resident #1 on 10/30/24 at 2:40 PM revealed Resident #1 did not provide any relevant information. Observation of Resident #1 on 10/30/24 at 2:40 PM revealed Resident #1 appeared with good personal hygiene and not in distress. Fall mat was in the room but moved to the side as the resident was up into her wheelchair. Resident #1 had a perimeter raised mattress. Resident #1 was sitting on the wheelchair and fell asleep. Resident #1 had a tray and footrests on her wheelchair. Resident #1 had a laceration to the left/top side of her head about 1.5 inches long with 3 staples. No hematoma or bruising noted. Resident #1 remained asleep and did not slouch or move to the sides. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA D on 10/31/24 at 10:10 AM revealed CNA D said she worked on 10/27/24 when Resident #1 fell in the dining room. CNA D said the staff, nurses or whoever was around, would let her know if the residents were done eating or ready to go back to their rooms. CNA D said that morning, Resident #1 was in the dining room for breakfast, but nobody informed her that Resident #1 was ready to go back to the hall/room. CNA D said she assisted another resident when she was informed that Resident #1 was on the floor in the dining room. CNA D said this was sometime after 9 AM. CNA D said she went to the dining room and her partner, CNA G, stayed in the hall. CNA D said the nurses, LVN J and LVN K, assessed Resident #1 and redirected her to not move as they held her head. CNA D said there was blood and she believed it was from Resident #1's head. CNA D said the ambulance took Resident #1 to the hospital. CNA D said they added a tray to Resident #1's wheelchair after this and it was probably for her to not to try to get up on her own. CNA D said she had seen Resident #1 try to get up on her own in the past and they had to redirect her to not get up as she cannot walk anymore, but she would forgeot. CNA D said Resident #1 also had a fall mat in her room which they ensured to place after they put her in bed and also ensured to leave the bed low. CNA D said Resident #1 was not on a 1:1 or special supervision, but since she was known to fall often, she checked on her frequently and kept an eye on her. Interview with RN E on 10/31/24 at 12:15 PM revealed RN E said she completed the admission for Resident #1. RN E said she completed the admission assessments including the fall risk evaluation. RN E said the fall risk score and whether or not the resident was considered at risk for falls was based on the questions asked. RN E said during the admission, FM 2 was present with Resident #1 and FM 2 mentioned that Resident #1 had fallen at home. RN E said FM 2 said that Resident #1 got up without telling anyone and by the time FM 2 saw Resident #1, she had fallen. RN E said she did not ask FM 2 follow up questions such as how long ago Resident #1 had fallen, when was the last time, how she fell , or how many falls she had. RN E said when a resident was admitted from the hospital, RN E reviewed hospital records for more information. RN E said Resident #1 was admitted from home and RN E could have asked FM 2 more questions regarding Resident #1's falls, but RN E did not. RN E said she had other questions to ask FM 2 for the admission and did not ask FM 2 more about the falls. RN E said it was important to accurately complete the assessments to know what assistance the resident required and to inform the staff on how to care for the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with LVN J on 10/31/24 at 12:45 PM revealed LVN J said she worked on 10/27/24 when Resident #1 fell . LVN J said LVN K wereas assigned to Resident #1's hallway. LVN J said she was in the nurse's station when HK A notified her that Resident #1 fell in the dining room. LVN J said there was nobody else in the dining room. LVN J said she checked on Resident #1, and she was on the floor with blood coming from her head. LVN J said LVN K wereas down the hall doing his round, so she called LVN K and he came to assist. LVN J said they assessed Resident #1. LVN J said Resident #1's feet were to the wheelchair and her head was next to the table. LVN J said Resident #1 did not remember what she tried to do but said she hit her head on the chair. LVN J said Resident #1 was alert and did not lose consciousness. LVN J said they called the MD and he ordered to send her to the hospital for an evaluation and for the cut on her head. LVN J said they applied pressure and were able to get the cut to stop bleeding. LVN J said the doors to the dining room were open when HK A notified her that Resident #1 fell . LVN J said there was nobody else in the dining room that she knew of. LVN J said they were moving residents back to the hall and to activities after breakfast, so she was not sure if they were going to move Resident #1 or were in the process of moving her. LVN J said Resident #1 had been in the dining room for breakfast that morning. LVN J said Resident #1 did not have the tray on her wheelchair likes she did now. LVN J said Resident #1 was sent to the hospital by ambulance. LVN J said ADON P reviewed the incidents and implemented interventions for falls. LVN J said she did not work with Resident #1 for other falls. Interview with HK A on 10/31/24 at 1:15 PM revealed HK A said on 10/27/24, he picked up trash and walked by the dining room when he heard a hit /noise and then saw Resident #1 on the floor. HK A said he did not know the resident's name, but he immediately informed the nurse, LVN J, who was at the nurse's station. HK A said he told LVN J that Resident #1 was on the floor. HK A said he had seen Resident #1 sitting at one of the tables before this, but he did not remember if there was anyone else in the dining room at that time. HK A said he was focused on his work. HK A said when he saw Resident #1 on the floor, he did not see any staff in the dining room which was why he called the nurse. HK A said there were no other residents either. HK A said the sound he heard was like a hit, but it was not a normal noise, and that was why he turned and checked what the noise was. HK A said the nurse ran to the dining room and checked on the resident. HK A said another nurse also went to help. HK A said he continued with his job duties. Interview with CNA G on 10/31/24 at 1:45 PM revealed CNA G said she worked on 10/27/24 with Resident #1. CNA G said she took Resident #1 to the dining room that morning for breakfast which usually started after 7 AM. CNA G said she went back to the hallway and waited for the meal trays to pass them out to the residents that did not go to the dining room. CNA G said after breakfast, the residents went to activities or were brought back to the hallway by other staff. CNA G said sometimes they would inform them if they needed to go get the residents from the dining room, but that morning she was not informed to get Resident #1 from the dining room after breakfast. CNA G said she assisted CNA D in changing another resident when they were informed that Resident #1 fell in the dining room. CNA G said CNA D went to the dining room and she stayed in the hallway to assist other residents and document. CNA G said she later went to the dining room to take back trays and saw Resident #1 on the floor while the nurses took care of her. CNA G said Resident #1 had the fall mat and low bed to prevent falls. CNA G said she had seen Resident #1 try to get up from the wheelchair when she had to go to the restroom, but she redirected her and took her to the restroom. (continued on next page)

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	676119	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rio Grande City Nursing and Rehabilitation Center	2530 Central Palm Dr Rio Grande City, TX 78582

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with AD H on 10/31/24 at 2:15 PM revealed AD H said she worked on 10/27/24, but when she arrived to work, Resident #1 had already fallen and was on the floor. AD H said the staff were tending to Resident #1 and redirected her to not move as they waited for the ambulance. AD H said Resident #1 attended activities more often now and appeared to enjoy the activities. AD H said she had seen Resident #1 try to get up, but she cannot walk so she explained to her to not get up. AD H said after the fall on 10/27/24, they added a tray to Resident #1's wheelchair but she did not know what the tray was for. AD H said when Resident #1 was in activities, she moved the tray to the side and placed Resident #1 at the table so she could play bingo and other games. AD H said Resident #1 tried to get up, but it was always that she needed to go to the restroom, so they took her to the restroom. Observation on 11/04/24 at 4:55 AM revealed CNAs rounding on residents. CNA R stood by Resident #1's room. Interview with LVN L on 11/04/24 at 8:40 AM revealed LVN L said he worked on 10/27/24 when Resident #1 fell . LVN L said he was doing his medication pass down the hallway and the CNAs were busy with another resident. LVN L said LVN J informed him that Resident #1 had fallen in the dining room. LVN L said Resident #1 had been in the dining room throughout the morning, sitting on her wheelchair, and he checked on her a few times. LVN L said Resident #1 was sleeping and he had tried to give Resident #1 her medications, but she had refused so he was going to try again. LVN L said Resident #1 had breakfast in the dining room and then stayed in the dining room. LVN L said he continued to give medications to the other residents and about 30 minutes later, they told him that Resident #1 fell . LVN L said that was his first weekend back to work and he had not worked in more than a month. LVN L said he was not aware that Resident #1 was at risk for falls. LVN L said there was nobody assigned to the dining room at that time, but the nurse's station was right across the dining room, and he had checked on Resident #1 maybe 30 minutes before he was told she fell . LVN L said he thought maybe it was Resident #1's preference to stay in the dining room, and she was sleeping, so he did not think he needed to move her. LVN L said he was not very familiar with Resident #1 and did not know if she would go to activities. LVN L said he and LVN J assessed Resident #1, applied pressure to the cut, stopped the bleeding, and called for the ambulance so they could send Resident #1 to the hospital. LVN L said Resident #1 did not know what happened, but they saw blood on the chair nearby Resident #1's head so they thought she had hit herself on the chair. LVN L said he was gone by the time Resident #1 returned to the facility and had not worked since then, so he was not sure what happened after or what else was implemented for her . Interview with FM 2 on 11/04/24 at 10:30 AM revealed FM 2 was present during Resident #1's admission process on 10/04/24. FM 2 said she told the nurse that Resident #1 was at risk for falls. FM 2 said Resident #1 had falls June 2023 and October 2023. FM 2 said in January 2024, the specialist saw Resident #1 and decided Resident #1 should no longer use the walker as Resident #1's mind was not connecting to her legs anymore. FM 2 said Resident #1 continued to try to get up at home, but FM 2 redirected her and tried her best to prevent falls. FM 2 said most of the time when Resident #1 tried to get up was because she needed to go to the restroom. FM 2 said the falls Resident #1 had last year were at night and because she needed to go to the restroom. FM 2 said she did not remember the nurse that completed the admission, but the nurse did not ask FM 2 about why Resident #1 fell , when she fell , or more information about the falls. FM 2 said the nurse did not ask when the last time was Resident #1 fell or how many falls she had. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with ADON P on 11/04/24 at 11:45 AM revealed ADON P reviewed falls and implemented interventions based on the investigation of the incident or the reason for the fall. ADON P said FM 2 informed them of Resident #1 falling at home in the past so they implemented the electrical bed to its lowest position that first night of admission on 10/04/24. ADON P said the risk for falls was added to the care plan on 10/06/24 after she had fallen on 10/05/24 and 10/06/24 as it was the weekend. ADON P said the baseline care plan had been completed during admission on 10/04/24. ADON P said Resident #1 was admitted from home so the nurse would have gotten the information and history from the family. ADON P said the nurse should have asked questions like when Resident #1 fell , were there any fractures/injuries, and did she follow up with the doctor. ADON P said if the incident happened within the week, they implemented the interventions, and then updated the care plan that day. ADON P said if it was during the weekend, the nurses implemented interventions based on what she instructed them to do and then she updated the care plan during the next business day. ADON P said sometimes the nurses added the interventions to the care plan that same day so it was shown on the CNAs' computers as well. ADON P said staff were in-serviced on changes or interventions implemented or during report with the CNAs and nurses, they communicated to the next shift what was implemented for any resident. ADON P said if Resident #1 had the baseline care plan trigger the fall risk from the day of admission, that could have prevented her falls but they were not familiar with her behaviors. ADON P said they did not know what kind of falls Resident #1 would have had. ADON P said once FM 2 came in more frequent, then FM 2 let them know what kind of behaviors Resident #1 had at home. ADON P said for the fall on 10/05/24, they implemented to toilet Resident #1 after meals. ADON P said for the fall on 10/06/24, they implemented the raised perimeter mattress. ADON P said for the fall on 10/15/24, they implemented an activities referral. ADON P said for the fall on 10/16/24, they implemented the fall mat. ADON P said for the fall on 10/27/24, they implemented antibiotics as Resident #1 had a UTI and they also tried the activity tray in an attempt for Resident #1 to get distracted with activities and did not try to get up. ADON P said on 10/27/24, the staff were going to take Resident #1 to activities, but she fell before they took her to activities. ADON P said she did not believe the staff forgot about Resident #1 or failed to supervise Resident #1. ADON P said Resident #1 was not on a special supervision or 1:1, but the nurses and staff monitored constantly. ADON P said were instructed to monitor frequently, maybe about every 15 minutes, to see where Resident #1 was at, at all times. ADON P said residents were rounded on every 2 hours or as needed, but the ones that fall, would be rounded on more frequent. ADON P said they provided in-services so the staff knew to check on the ones that fall more often and everyone else, every 2 hours. ADON P said they evaluated interventions by asking the CNAs/staff if the interventions were effective or should continue to be used. ADON P said the injury on 10/27/24, cut to head with 3 staples, was the only injury that resulted from the falls for Resident #1. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DON on 11/04/24 at 1:00 PM revealed the DON said Resident #1 was at risk for falls since admission. The DON said Resident #1's first fall was on 10/05/24 and she fell after lunch time as she was trying to go to the restroom, so they added the intervention of toileting after meals. The DON said on 10/06/24, Resident #1 fell out of bed, so they added the raised perimeter mattress. The DON said on 10/15/24, Resident #1 fell in the hallway out of the wheelchair, and they implemented an activities referral. The DON said Resident #1 had been more engaged in activities. The DON said on 10/16/24, the fall mat was implemented. The DON said she was not sure if Resident #1 had the thicker or thinner mat. The DON said on 10/27/24, Resident #1 fell out of the wheelchair in the dining room. The DON said she did not know why Resident #1 was in the dining room alone after breakfast. The DON said Resident #1 ended up with a laceration to her head with 3 staples from the last fall on 10/27/24. The DON said Resident #1 was sent to the hospital and it was determined she also had a UTI. The DON said Resident #1 returned to the facility on [DATE] and had orders for antibiotics for the UTI and care for the laceration which were carried out and followed. The DON said she in-serviced all staff to ensure all residents were out of the dining room after meals. The DON said they implemented a tray attached to the front of Resident #1's wheelchair and Resident #1 was able to move the tray, but it seemed to help in her not trying to get up. The DON said she did not think if the fall risk was triggered since the baseline care plan, that it would have made a difference in preventing Resident #1 from falling. The DON said if the family had mentioned to RN E that Resident #1 had falls in the past, the nurse should have asked follow-up questions like when the last fall was, how many falls has she had, etc. The DON said she did not think Resident #1 would have been at risk of further injury from the fall on 10/27/24. The DON said she just needed to keep educating staff. The DON said the laceration Resident #1 sustained on 10/27/24 was the only injury she had from the falls. The DON said Resident #1 was not injured from the other 4 falls. The DON said she did not think Resident #1 would have been at risk of harm or injury for the other falls on 10/05/24, 10/06/24, 10/15/24, and 10/16/24. The DON said she believed there was enough supervision, but they just did not know Resident #1 well enough to implement interventions sooner for falls. The DON said she instructed the night staff to sit by Resident #1's door or close by so they can hear or keep an eye on her in case she tried to get up or they heard her moving around in bed. The DON said the staff were in-serviced to round on the residents every 2 hours or as needed. The DON said in between the rounds, the staff knew to answer call lights, walk up and down the hall, and check on residents that fall more frequent. The DON said they in-service all staff, including the night shift staff. The DON said she ensured staff were consistent with checking on the residents or rounding with the in-services, with the nurses checking on the staff, and she also did random spot checks. The DON said there was no specific timeframe of checking on the residents, not like every 15 minutes, every 30 minutes, every hour, but the staff knew to check on the residents and round as needed . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the ADM on 11/04/24 at 2:20 PM revealed the ADM said they discussed as a team for falls and interventions, but ultimately the clinical department, DON/ADON, decided and implemented interventions. The ADM said it was important to care plan interventions appropriately to know how to care for the resident. The ADM said if during the initial assessment, Resident #1 had been identified as fall risk, then the nurse who completed the initial assessment, should have asked more questions, and gathered more details if the family mentioned Resident #1 had fallen before. The ADM said the nurses were usually good about documenting and completing the assessments. The ADM said FM 2 said that at home, Resident #1 was sort of on a 1:1 with FM 2. The ADM said she explained to the family that the facility could not have a 1:1 with Resident #1. The ADM said they tried their best to keep Resident #1 safe. The ADM said unfortunately, things happened in a blink of an eye. The ADM said there was an intervention implemented for each fall and the interventions have helped a lot. The ADM said some of the interventions were a fall mat, electrical bed to its lowest position, and increased activities. The ADM said for the first 4 falls on 10/05/24, 10/06/24, 10/15/24, and 10/16/24, Resident #1 was not injured. The ADM said for the fall on 10/27/24, Resident #1 sustained the cut to her head, and she received 3 staples, but it was not suspicious, or a result of abuse or neglect based on their investigation. The ADM said they could have possibly implemented interventions sooner to prevent falls, but the more important interventions were already in place such as the low bed and fall mat for the falls that happened in her room. The ADM said for the falls that happened out of the room, there was always supervision provided. The ADM said Resident #1 was not left alone in the hallway and was not left in the dining room alone. The ADM said Resident #1 was monitored in activities. The ADM said in the hallway, there were CNAs to monitor Resident #1, but then she fell twice in the hallway. The ADM said the CNAs could not just be with Resident #1 as they had to round and assist other residents as well. The ADM said when Resident #1 fell in the hallway, she fell right by the wheelchair, as she forgot she could not get up and she fell quickly. The ADM said the staff were instructed to round on the residents at minimum, every 2 hours. The ADM said the staff provided care such as peri care or changing every 2 hours, and then everything else was as needed. The ADM said if there was a call light on, the staff should have checked right away. The ADM said their expectation for the staff was for them to walk back and forth, peek in, see if the residents needed water, peri care, change, shower, etc. The ADM said the staff were not given a timeframe. The ADM said for those residents that were frequent fallers, tried to place them in the rooms by the computer where the CNAs documented to keep a closer eye on them or were able to hear if something happened. The ADM said there was no set time of like 10 minutes, 15 minutes, etc. The ADM said Resident #1 was not on any specific timeframe to be rounded on. The ADM said for the first falls, on 10/05/24, 10/06/24, 10/15/24, and 10/16/24, Resident #1 did not have any injuries. The ADM said for the fall on 10/27/24, Resident #1 sustained the cut to her head, they believed from Resident #1 hitting the chair, but she did not believe anything worse could have happened . Record review of the Fall Prevention Program date implemented: 08/15/22 reflected: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. 7.a. Interventions will be monitored for effectiveness. 7.b. The plan of care will be revised as needed.