STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	04/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview and record review the facility failed to immediately inform the resident, consult with the resident's physician and notify, consistent with his or her authority, the resident representative(s) when there was a an accident involving the resident which resulted in an injury and had the potential for requiring physician intervention, and or a significant change in the resident's physical, mental, or psychosocial status for 1 of 4 residents (Resident #1) reviewed for notification to the physician. LVN A failed to report to the physician and Resident #1's representative a change of condition when Resident #1 was discovered injured and confused on the floor by her bedside on 04/20/2025 and was hospitalized and diagnosed with acute congested heart failure fluid overload, in addition to right rib fractures to the 3rd, 7th and 9th ribs, 3 hours later. The noncompliance was identified as PNC. The IJ began on 4/20/2025 and ended on 4/25/2025. Facility had implemented intervention on 04/25/2025 prior to surveyor entrance on 04/25/2025. This failure could place residents at risk for harm. The findings include: A record review of Resident #1's admission record, dated 4/25/2025, revealed an admitted [DATE]. Resident #1 had diagnoses which included end stage renal disease (kidney failure) and hypertension (high blood pressure). A record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 was a [AGE] year-old female who was admitted to the facility for long term care after a hospitalization related to a fall. Resident #1 was assessed with a BIMS score of 13 out of a possible 15, which indicated intact cognition. Resident #1 was assessed with minimal difficulty hearing, with clear speech, could usually make herself understood and could usually understand others. Resident #1 was assessed with adequate vision and did not wear glasses. The resident was assessed without a mood disturbance, hallucinations, and or a change in mental status. Resident #1 was assessed with the Important preference of having family or a close friend involved in discussions about your care. Resident #1 was assessed as being independent with Activities of Daily Life, used a manual wheelchair, and had weakness in both arms. Resident #1 was assessed with occasional urinary incontinence and frequent bowel incontinence. Resident #1 was assessed as medically complex. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's care plan, dated 3/25/2024, revealed, The resident has bowel incontinence . Check resident every two hours and assist with toileting as needed A record review of Resident #1's hospital record, dated 3/19/2025 , revealed Resident #1 was diagnosed with pancreatic cancer which has spread to other parts of her body and had a fall on 3/10/2025 at her home and was hospitalized . The hospital documented Resident #1's family reported general weakness and Resident #1 had lost the ability to self-transfer from her bed to her wheelchair. A record review of Resident #1's nursing progress notes, on 4/19/2025 prior to 4/20/2025, revealed Resident #1 had increased episodes of altered mental status to which the physician and family were notified, Nursing Progress Note . 4/19/2025 07:00:00 (7:00 AM) . Nursing . Registered Nurse (B) . Note Text: Pt had increased confusion, asked multiple times ' Are you going to kill me?' stating after that 'I cannot hear' . Nursing Progress Note . 4/19/2025 18:38:00 (6:38 PM) . Registered Nurse B . Dr . (physician's name) was notified of the pt's increase confusion. A record review of Resident #1's nurse progress note, dated 4/20/2025 at 4:22 AM, revealed LVN A documented, . Location of event: Resident Room Level of pain from 0-10 . pain:0 . Injury: Yes . Describe any injuries: Abrasion to bilat knees, 0 bleeding noted. CNAs reported that during rounds they found resident kneeling on her knees next to bedside on fall mat. CNA also reported resident was assisted back into bed by CNAs. This nurse entered resident's room and observed resident in bed. Resident noted to have abrasions to bilateral knees: without bleeding. Areas cleansed with wound cleanser and (name brand small bandage) applied to each knee. Initial Treatment/New Orders: Areas cleansed with wound cleanser and (name brand small bandage) applied knee. Resident Statement: When asked why resident was kneeling on floor resident stated, 'I don't know.' Name of MD/NP notified: (NP) N.P. Date/time of notification: 04/21/2025 at 2:02 AM. Name of RP notified: (Resident #1's Representative) Date/time of notification: 04/20/2025 4:22 AM. Interventions: bed in low position, fall mat in place. Call light in reach . A record review of Resident #1's nurse progress note, dated 4/20/2025 at 7:23 AM, revealed RN B documented Resident #1 was assessed with a change in status and sent to the hospital by EMS 911, (Resident #1) was transferred to a Hospital on 04/20/2025 at 7:30 AM related to Pt sic(patient) had decreased LOC sic(level of conscience), disoriented, moving in bed constantly erratically. Pt had bruises on left knee, left wrist and palm. A record review of Resident #1's hospital admission records, dated 4/20/2025, revealed she was admitted after a fall at the nursing home and was diagnosed with liver cancer, confusion, and rib fractures, history of present illness chief complaint: patient is a [AGE] year-old female with past medical history significant for end stage renal disease on hemodialysis Mondays, Wednesdays, and Fridays, hypertension, recently diagnosed metastatic gastrointestinal cancer (cancer of the digestive system which has spread to other parts of the body). Presents to our emergency department from nursing home after she had fallen. Per (Resident representative) patient had fallen from bed height at nursing home and became altered. Apparently her usual state until her fall today sic(4/20/2025). The patient had significant change in her mental status. In the emergency department she was found to have bilateral pleural effusion [sic](fluid in the lungs), moderate pericardial effusion sic (fluid around the heart), right rib fracture 3-7, 9 and CT sic(computed tomography scan) findings of metastasis sic(spread of cancer) to liver. patient currently altered and unable to cooperate with exam. She has a 3cm by 3-centimeter contusion sic(bruise) over the medial aspect of the knee. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 4/26/2025 at 10:32 AM revealed Resident #1 presented at the hospital asleep in her bed. Resident #1's representative was at the bedside and stated she was not given a report about Resident #1's fall at 4:00 AM on 4/20/2025 until she arrived at the nursing home to visit Resident #1 around 7:00 AM. Resident #1's representative stated she arrived and discovered Resident #1 was confused and had injuries to her knees, Resident #1's representative stated, I reported the injuries to the CNA and the nurse. Resident #1's representative stated after Resident #1's Representative alerted RN B then RN B assessed Resident #1 and called 911 , EMS arrived and took Resident #1 to the hospital where she was discovered with broken ribs and bruises. Resident #1's representative stated she was upset and concerned she was not alerted to the fall and confusion and felt Resident #1 was delayed in receiving care and stated, I don't know if the doctor was called. During an interview on 4/26/2025 at 12:30 PM, RN B stated Resident #1 begun to be confused and hallucinating on 4/19/2025 and reported the change to the physician and the physician had not given any new orders. RN B stated at 10:00 PM, she ended her shift and gave a report to LVN A. RN B stated she returned to work the following morning, 4/20/2025 at 7:20 AM, and received a report from LVN A that Resident #1 had fallen around 4 AM. RN B stated she assessed Resident #1 with Resident #1's representative at the bedside and discovered Resident #1 was confused with bruises and bandages to her knees and called EMS 911 . During an interview on 4/26/25 at 4:15 PM, LVN A stated she was alerted by CNAs Resident #1 was discovered on the floor by her bedside and the CNAs picked her up and placed her back in bed . LVN A stated she assessed Resident #1 in her bed, discovered her knees were red and abraded without bleeding, performed first aid, and applied a small self-adhesive bandages to her knees. LVN A stated Resident #1 could not say how she came to be on her knees next to the bed and no one witnessed the way she became to be on her knees. LVN A stated she had not considered Resident #1's incident a fall and Resident #1 had not complained of pain and was calm and sleepy at 4:00 AM. LVN A stated she documented she reported the incident to Resident #1's physician and her representative but had not reported the incident to the physician nor Resident #1's representative. LVN A stated she documented she reported to the NP and the representative because she had intended to call the NP during business hours. LVN A stated, I called Resident #1's representative and no one answered so I left a message . During an interview on 4/26/2025 at 5:40 PM the Medical Director stated his expectation for unwitnessed falls with injuries was for nursing staff to call and report the finding to a physician and or their Nurse Practitioner within a reasonable time for example an hour after the assessment. The MD stated the risk to residents could have been delayed care. During a joint interview on 4/26/2025 at 5:50 PM, the Administrator and the DON stated they had not recognized LVN A had not followed facility protocols, such as reporting the incident to the physician and to Resident #1's Representative, for Resident #1's unwitnessed fall on 4/20/2025 until early 4/25/2025 and began an investigation and self-reported the incident to the state survey agency. The Administrator and the DON stated they suspended LVN A pending the investigation, assessed all the residents for injuries, developed and implemented in-services for all staff which included fall protocols and reporting to the physician and residents' families. The DON and the Administrator stated their expectations for LVN A was for her to have followed the risk management fall protocol which included a report to the physician and a report to the family. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews from 4/26/2025 to 4/27/2025 with 44 of the 69 nursing staff which included all shifts revealed all interviewed were able to confirm they received the in-service which covered unwitnessed falls, assessing residents post falls, documenting the assessments, notifying the physician, and family. A record review of the facility's Risk Management Reporting; Completion Of policy, dated 4/25/2025, revealed The facility will complete an Event report in Risk Management for variances that occur within the facility. Variances include falls, skin tears, bruises, abrasions, lacerations, fractures . All break in planes are considered a fall. All Events resulting in a change in status of a resident must be reported immediately to the attending physician and family member/legal representative of the resident. Documentation of the notification and subsequent interventions and comments must be recorded in the resident's clinical record and/or on the Event Note. Any physician order should be followed. All unwitnessed falls or head injuries require neuros per facility policy. A record review of the facility's Notifying the Physician of Change in Status policy, dated 3/11/2013, revealed The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention . 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record . 5. The resident's family member or legal guardian should be notified of significant change in resident's status . 7. The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative, the physician's response, the physician's orders and the resident's status and response to interventions PNC verification The facility identified the deficient practice, took actions to identify residents at risk for the deficiency, and developed and implemented, saftey survey assesments (Quality of Life Rounds) for 88 of 88 residents, in-services for fall protocols and the ANE prevention protocols to the entire staff which included nursing staff. Record review of the facility's nursing roster revealed 113 employees which included 69 nurses and CNAs. A record review of the facility ' s department of social services Quality Life Rounds dated 4/25/2025 revealed 88 of the facility ' s census of 88 residents were assessed for safety with no one evidenced for injuries. Record review of the facility's in-services titled fall protocol and ANE prevention, dated 4/25/2025, revealed 113 staff received the in-service, and the training which included, Falls: all falls require risk management assessments to include reporting to the physician, resident family representative, and immediate supervisor, and SBAR (Situation, Background, Assessment and Recommendation). All unwitnessed falls require neuro checks During an interview on 4/26/2025 at 9:00 PM LVN C stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN C stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 9:04 PM RN B stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. RN B stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:10 PM LVN D stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. LVN D stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:14 PM LVN E stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. LVN E stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:18 PM RN F stated she as needed and the 2:00 PM to 10:00 PM shifts on the weekends. RN F stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:20 PM LVN G stated she as needed and the 2:00 PM to 10:00 PM shifts on the weekends. LVN G stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:22 PM LVN H stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN H stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:24 PM LVN I stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN I stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 9:29 PM CNA J stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA J stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 9:59 PM CNA K stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA K stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:01 PM CNA L stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA L stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:03 PM CNA M stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA M stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 1:48 PM CNA N stated he worked the 6:00 AM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA N stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 2:38 PM CNA O stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA O stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 9:59 PM RN P stated she worked the 6:00 AM to 10:00 PM shifts on the weekends and on 4/25/2025 she received in-services which included ANE prevention and Fall Protocols, such as assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 2:38 PM CNA Q stated he worked the 6:00 AM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA Q stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:11 PM CNA R stated she worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA R stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 10:14 PM RN S stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. RN S stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. The noncompliance was identified as PNC. The IJ began on 4/20/2025 and ended on 4/25/2025. The facility had corrected the noncompliance before the survey began.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41937 Based on observation, interview, and record review the facility failed to ensure, based on the comprehensive assessment of a resident, residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 4 residents (Resident #1) reviewed quality of care. On 4/20/2025, early morning, LVN A failed to provide quality care for Resident #1, by not following facility protocol for an unwitnessed fall with injuries to begin neurological assessments, reporting to the physician and the residents representative, when Resident #1 was discovered on the floor by her bedside and hospitalized for chronic heart failure with fluid overload in addition to fractures to right ribs 3rd, 7th and 9th ribs, 3 hours later. On 4/20/2025, CNAs Y and Z discovered Resident #1 on the floor and repositioned her back into bed without having the nurse assess prior to the repositioning. The noncompliance was identified as PNC. The IJ began on 4/20/2025 and ended on 4/25/2025. Facility had implemented interventions on 04/25/2025 prior to surveyor entrance on 04/25/2025. This failure could place residents at risk for harm . The findings include: A record review of Resident #1's admission record, dated 4/25/2025, revealed an admitted [DATE] with diagnoses which included end stage renal disease (kidney failure) and hypertension (high blood pressure). A record review of Resident #1's admission MDS dated [DATE] revealed Resident #1 was a [AGE] year-old female admitted for long term care after a hospitalization related to a fall. Further review revealed Resident #1 was assessed with a BIMS score of 13 out of a possible 15 which indicated intact cognition. Resident #1 was assessed with minimal difficulty hearing, with clear speech, could usually make herself understood and could usually understand others. Resident #1 was assessed with adequate vision and did not glasses. Resident was assessed without a mood disturbance, hallucinations, and or a change in mental status. Resident #1 was assessed with the Important preference of having family or a close friend involved in discussions about your care. Resident #1 was assessed as being independent with Activities of Daily Life, used a manual wheelchair, and had weakness in both arms. Resident #1 was assessed with occasional urinary incontinence and frequent bowel incontinence. Resident #1 was assessed as medically complex. A record review of Resident #1's care plan dated 3/25/2024 revealed, The resident has bowel incontinence . Check resident every two hours and assist with toileting as needed A record review of Resident #1's hospital record dated 3/19/2025 revealed, Resident #1 was diagnosed with pancreatic cancer which has spread to other parts of her body and had a fall on 3/10/2025 at her home and was hospitalized . The hospital documented Resident #1's family reported general weakness and Resident #1 has lost the ability to self-transfer from her bed to her wheelchair. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A record review of Resident #1's nursing progress notes, on 4/19/2025 prior to 4/20/2025, revealed Resident #1 had increased episodes of altered mental status to which the physician and family were notified, Nursing Progress Note . 4/19/2025 07:00:00 (7:00 AM) . Nursing . Registered Nurse (B) . Note Text:; Pt had increased confusion, asked multiple times ' Are you going to kill me?' stating after that 'I cannot hear' . Nursing Progress Note . 4/19/2025 18:38:00 (6:38 PM) . Registered Nurse B . Dr . (physician's name) was notified of the pt's increase confusion. A record review of Resident #1's nurse progress note dated 4/20/2025 at 4:22 AM revealed LVN A documented, . Location of event: Resident Room Level of pain from 0-10 . pain:0 . Injury: Yes . Describe any injuries: Abrasion to bilat knees, 0 bleeding noted. CNAs reported that during rounds they found resident kneeling on her knees next to bedside on fall mat. CNA also reported resident was assisted back into bed by CNAs. This nurse entered resident's room and observed resident in bed. Resident noted to have abrasions to bilateral knees: without bleeding. Areas cleansed with wound cleanser and (name brand small bandage) applied to each knee. Initial Treatment/New Orders: Areas cleansed with wound cleanser and (name brand small bandage) applied knee. Resident Statement: When asked why resident was kneeling on floor resident stated, I don't know. Name of MD/NP notified: (NP) N.P. Date/time of notification: 04/21/2025 2:02 AM. Name of RP notified: (Resident #1's Representative) Date/time of notification: 04/20/2025 4:22 AM. Interventions: Bed in low position, fall mat in place. Call light in reach. A record review of Resident #1's nurse progress note dated 4/20/2025 at 7:23 AM revealed RN B documented Resident #1 was assessed with a change in status and sent to the hospital by EMS 911, (Resident #1) was transferred to a Hospital on 04/20/2025 7:30 AM related to Pt sic(patient) had decreased LOC sic(level of conscience), disoriented, moving in bed constantly erratically. Pt had bruises on left knee, left wrist and palm. A record review of Resident #1's hospital admission records dated 4/20/2025 revealed she was admitted after a fall at the nursing home and was diagnosed with liver cancer, confusion, and rib fractures, history of present illness chief complaint: patient is a [AGE] year-old female with past medical history significant for end stage renal disease on hemodialysis Mondays, Wednesdays, and Fridays, hypertension, recently diagnosed metastatic gastrointestinal cancer (cancer of the digestive system which has spread to other parts of the body). Presents to our emergency department from nursing home after she had fallen. Per (Resident representative) patient had fallen from bed height at nursing home and became altered. Apparently her usual state until her fall today sic(4/20/2025). The patient had significant change in her mental status. In the emergency department she was found to have bilateral pleural effusion sic(fluid in the lungs), moderate pericardial effusion sic(fluid around the heart), right rib fracture 3-7, 9 and CT sic(computed tomography scan) findings of metastasis sic(spread of cancer) to liver. patient currently altered and unable to cooperate with exam. She has a 3cm by 3-centimeter contusion sic(bruise) over the medial aspect of the knee. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 4/26/2025 at 10:32 AM revealed Resident #1 presented at the hospital asleep in her bed. Resident #1's representative was at the bedside and stated she was not given a report about Resident #1's fall at 4:00 AM on 4/20/2025 until she arrived at the nursing home to visit Resident #1 around 7:00 AM. Resident #1's representative stated she arrived and discovered Resident #1 was confused and had injuries to her knees, Resident #1's representative stated, I reported the injuries to the CNA and the nurse. Resident #1's representative stated after Resident #1's Representative alerted RN B then RN B assessed Resident #1 and called 911 , EMS arrived and took Resident #1 to the hospital where she was discovered with broken ribs and bruises. Resident #1's representative stated she was upset and concerned she was not alerted to the fall and confusion and felt Resident #1 was delayed in receiving care and stated, I don't know if the doctor was called. During an interview on 4/26/2025 at 12:30 PM, RN B stated Resident #1 begun to be confused and hallucinating on 4/19/2025 and reported the change to the physician and the physician had not given any new orders. RN B stated at 10:00 PM, she ended her shift and gave a report to LVN A. RN B stated she returned to work the following morning, 4/20/2025 at 7:20 AM, and received a report from LVN A that Resident #1 had fallen around 4 AM. RN B stated she assessed Resident #1 with Resident #1's representative at the bedside and discovered Resident #1 was confused with bruises and bandages to her knees and called EMS 911 . During an interview on 4/26/25 at 4:15 PM, LVN A stated she was alerted by CNAs Resident #1 was discovered on the floor by her bedside and the CNAs picked her up and placed her back in bed . LVN A stated she assessed Resident #1 in her bed, discovered her knees were red and abraded without bleeding, performed first aid, and applied a small self-adhesive bandages to her knees. LVN A stated Resident #1 could not say how she came to be on her knees next to the bed and no one witnessed the way she became to be on her knees. LVN A stated she had not considered Resident #1's incident a fall and Resident #1 had not complained of pain and was calm and sleepy at 4:00 AM. LVN A stated she documented she reported the incident to Resident #1's physician and her representative but had not reported the incident to the physician nor Resident #1's representative. LVN A stated she documented she reported to the NP and the representative because she had intended to call the NP during business hours. LVN A stated, I called Resident #1's representative and no one answered so I left a message . During an interview on 4/26/2025 at 5:40 PM the Medical Director stated his expectation for unwitnessed falls with injuries was for nursing staff to call and report the finding to a physician and or their Nurse Practitioner within a reasonable time for example an hour after the assessment. The MD stated the risk to residents could have been delayed care. During a joint interview on 4/26/2025 at 5:50 PM, the Administrator and the DON stated they had not recognized LVN A had not followed facility protocols, such as reporting the incident to the physician and to Resident #1's Representative, for Resident #1's unwitnessed fall on 4/20/2025 until early 4/25/2025 and began an investigation and self-reported the incident to the state survey agency. The Administrator and the DON stated they suspended LVN A pending the investigation, assessed all the residents for injuries, developed and implemented in-services for all staff which included fall protocols and reporting to the physician and residents' families. The DON and the Administrator stated their expectations for LVN A was for her to have followed the risk management fall protocol which included a report to the physician and a report to the family. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews from 4/26/2025 to 4/27/2025 with 44 of the 69 nursing staff which included all shifts revealed all interviewed were able to confirm they received the in-service which covered unwitnessed falls, assessing residents post falls, documenting the assessments, notifying the physician, and family. A record review of the facility's Risk Management Reporting; Completion Of policy, dated 4/25/2025, revealed The facility will complete an Event report in Risk Management for variances that occur within the facility. Variances include falls, skin tears, bruises, abrasions, lacerations, fractures . All break in planes are considered a fall. All Events resulting in a change in status of a resident must be reported immediately to the attending physician and family member/legal representative of the resident. Documentation of the notification and subsequent interventions and comments must be recorded in the resident's clinical record and/or on the Event Note. Any physician order should be followed. All unwitnessed falls or head injuries require neuros per facility policy. A record review of the facility's Notifying the Physician of Change in Status policy, dated 3/11/2013, revealed The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention . 1. The nurse will notify the physician immediately with significant change in status. The nurse will document signs and symptoms of significant change, time/date of call to physician, and interventions that were implemented in the resident's clinical record . 5. The resident's family member or legal guardian should be notified of significant change in resident's status . 7. The nurse will document all attempts to contact the physician, all attempts to notify the family and/or legal representative, the physician's response, the physician's orders and the resident's status and response to interventions PNC verification The facility identified the deficient practice, took actions to identify residents at risk for the deficiency, and developed and implemented, saftey survey assesments (Quality of Life Rounds) for 88 of 88 residents, in-services for fall protocols and the ANE prevention protocols to the entire staff which included nursing staff. Record review of the facility's nursing roster revealed 113 employees which included 69 nurses and CNAs. A record review of the facility ' s department of social services Quality Life Rounds dated 4/25/2025 revealed 88 of the facility ' s census of 88 residents were assessed for safety with no one evidenced for injuries. Record review of the facility's in-services titled fall protocol and ANE prevention, dated 4/25/2025, revealed 113 staff received the in-service, and the training which included, Falls: all falls require risk management assessments to include reporting to the physician, resident family representative, and immediate supervisor, and SBAR (Situation, Background, Assessment and Recommendation). All unwitnessed falls require neuro checks During an interview on 4/26/2025 at 9:00 PM LVN C stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN C stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 9:04 PM RN B stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. RN B stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:10 PM LVN D stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. LVN D stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:14 PM LVN E stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift and the 2:00 PM to 10:00 PM shifts on the weekends. LVN E stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:18 PM RN F stated she as needed and the 2:00 PM to 10:00 PM shifts on the weekends. RN F stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:20 PM LVN G stated she as needed and the 2:00 PM to 10:00 PM shifts on the weekends. LVN G stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:22 PM LVN H stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN H stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 9:24 PM LVN I stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. LVN I stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 9:29 PM CNA J stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA J stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 9:59 PM CNA K stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA K stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:01 PM CNA L stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA L stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:03 PM CNA M stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA M stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 1:48 PM CNA N stated he worked the 6:00 AM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA N stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 2:38 PM CNA O stated he worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA O stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 9:59 PM RN P stated she worked the 6:00 AM to 10:00 PM shifts on the weekends and on 4/25/2025 she received in-services which included ANE prevention and Fall Protocols, such as assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. During an interview on 4/26/2025 at 2:38 PM CNA Q stated he worked the 6:00 AM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA Q stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. During an interview on 4/26/2025 at 10:11 PM CNA R stated she worked the 2:00 PM to 10:00 PM shift and on 4/25/2025 he received in-services which included ANE prevention and Fall Protocols, such as alerting the nurse whenever anyone falls and reporting any suspected ANE. CNA R stated he would not reposition anyone and would stay with the Resident until the nurse assessed the Resident for injuries. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/26/2025 at 10:14 PM RN S stated she worked the Monday through Friday 6:00 AM to 2:00 PM shift. RN S stated she received the in-services regarding ANE prevention and risk management protocols for falls which included assessing the Resident for injuries, documenting the fall by starting the incident report, SBARing (reporting to the doctor) the physician, reporting the incident to the Resident's representative, alerting the nursing supervisor, and fully documenting the details in the residents nursing notes. The noncompliance was identified as PNC. The IJ began on 4/20/2025 and ended on 4/25/2025. The facility had corrected the noncompliance before the survey began.