STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676127	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Hills Rehabilitation and Healthcare Center	5600 Davis Blvd North Richland Hills, TX 76180

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 1 of 5 residents (Resident #10) reviewed for physical environment. The facility staff failed to remove all kitchen coffee from Resident #10's room cups located on the toilet after resident use. The facility staff failed to discard used disposable gloves, and a plastic cup after use. The facility staff failed to ensure Resident #10's incontinent briefs and dirty clothing were properly stored and discarded. The facility staff failed to ensure Resident #10's mattress properly fit her bed and not move from the position. These failures could place residents at risk for a diminished quality of life, cross contamination, falls, injuries, and unsanitary environment. Findings included: Record review of Resident #10's face sheet dated 06/24/2025 reflected the resident was a [AGE] year-old female that was admitted on [DATE] with the following diagnoses: Congestive Heart Failure (heart failure), Dementia (memory decline) in other diseases classified elsewhere, unspecified severity, with psychotic disturbance . Record review of Resident #10's quarterly MDS dated [DATE] reflected she had a BIMS score of 13, indicating she was cognitively intact. The resident mood and behaviors indicated 0 indicating Resident #10 had no mood issues. (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's care plan dated 05/06/2025 reflected) during MDS assessment resident specifies a preference not to be asked question Q0500 Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community? . Assist with repositioning as appropriate .Resident is on diuretic therapy r/t HTN/CHF. May cause dizziness, postural hypotension, fatigue, and an increased risk for falls. Observe or possible side effects q-shift. Created 05/06/2025 . Resident is at risk for falls due to: Hx falls, Mobility impairment, Dementia with poor safety awareness, unsteady gait. Intervention increased staff supervision with intensity based on resident need, edited 06/23/2025 Resident requires hospice as evidenced by terminal illness of Dementia, Edited on 06/23/2025 Resident ADLs Functional Bed Mobility: set-up/sup Assist: 1, Transfers: min Assist: 1, Dressing: min Assist: 1, Eating: set/up Assist: 1, Toileting: touch, Assist: 1, Personal Hygiene: touch Assist: 1, Bathing: touch to min Assist: 1. Resident manages brief changes with setup but leaves soiled briefs and gloves in bathroom, check bathroom frequently for soiled items created on 06/24/2025. Record review of Resident #10's MD orders dated 06/25/25, reflected as follows: Dapagliflozin propanediol 5 mg tablet Once a Day 1 tab, oral, Once A Day E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease . 05/06/2025 . Furosemide 20 mg tablet Once a Day 1 TAB, oral, Once A Days, Chronic systolic (congestive) heart failure 05/05/2025 Hyoscyamine sulfate 0.125 mg tablet Every 2 Hours - PRN 1 tab, oral, every 2 Hours - PRN, for excessive secretions .Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance. 05/05/2025 .Morphine concentrates 100 mg/5 mL (20 mg/mL) solution Every 1 Hour - PRN 0.5 ml, oral, Every 1 Hour - PRN, for pain/sob. 05/05/2025 . Lisinopril-hydrochlorothiazide 20-25 mg tablet Once a Day 1 TAB, oral, Once A Day, HOLD IF SBP (top number on BP) < 110 OR DBP (bottom number) < 60 I13.0: Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease 05/05/2025 .Mirtazapine 7.5 mg tablet At Bedtime 1 tab, oral, At Bedtime F33.1: Major depressive disorder, recurrent, moderate 05/22/2025 .Sertraline 100 mg once 1 tab, oral once a day for Major depressive disorder recurrent moderate, dated 06/25/2025. The following orders are listed to provide a clear picture of Resident #10's clinical conditions that could affect her environmental safety. Record review of Resident #10's hospice sign-in sheet reflected that the hospice aide's last visit was on 6/23/2025. The time in and time out was left blank. In an observation and attempted interview with Resident #10 on 06/24/2025at 11:20 AM, revealed the resident was not in the room. Her bed was observed with the mattress positional off to the left side of the bed with 1/3 of the bed frame exposed with a metal brown frame exposed and a plastic cup under the bed. The bed was not made, there was no pillowcase on the two pillows (1 white pillow and 1 light blue pillow). Observation of Resident #10's bathroom revealed several clear used disposable gloves lying in the sink with a tube of toothpaste, toothbrush, and a plastic 2-ounce clear cup. The toilet was observed with a tan coffee mug and a burgundy coffee mug placed on the back of the toilet frame near the assistance bar. The surveyor observed a shower chair to the immediate right used clothing for laundry (jeans and gray shirt). Further down at the end of the shower was a gray bed pan with disheveled (opened single briefs) briefs that were not covered. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with CNA G on 06/24/2025 at 11:25 AM revealed that she was the assigned CNA for Resident #10. She stated that prior to her going to break at 10:22 AM the room mattress was not moved off the metal frame. CNA G reported that Resident #1 left the gloves in the bathroom sink and she confirmed that the briefs were clean and placed in the bathroom to be accessible for the resident. CNA G stated that staff were expected to check resident's rooms during their shift for environment issues that could result in unsanitary conditions in the room and bathroom. CNA G stated that she was responsible for disposing of the briefs and gloves immediately after use for sanitation purposes, and dirty clothing should be discarded immediately to the laundry. CNA G said Resident #10 was able to ambulate independently, and she was capable of changing her own clothing and briefs. CNA G said, she believes that Resident #10 moved her mattress to the left leaving while moving or getting out of the bed, and this caused the mattress to slide and expose the metal frame. CNA G said Resident #10 the briefs on the floor near the shower, and they were clean, however she was not sure and could not provide information about the dirty clothing left in the shower chair and coffee cups in the bathroom. CNA G said coffee cups should be returned to the kitchen after use. CNA G proceeded to position Resident #10's mattress appropriately over the bed frame. CNA G said all nursing staff (CNA's and Nurses) were responsible for maintaining a clean, safe, and sanitary environment. CNA G stated failing to properly discard PPE, briefs, and laundry could place residents at risk of infections, cross contamination, and reuse of dishes stored in the bathroom and residents could be injured by falling or skin tears from the frame while transferring independently. During an interview and observation with the ADON on 06/24/25 at 11:45 AM concerning Resident #10's room, she observed the concerns in Resident #10's shower. The ADON stated that the resident received hospice care, and the bed was provided by the hospice program. She was not sure when the hospice aide last visited Resident #110. The ADON checked Resident #10's hospice log and the last entry was dated 06/23/2025 and the time in and out were left blank and unknown. The ADON stated that the bed was changed out. In a brief interview on 06/24/2025 at 3:00 PM with the Administrator, he reported that upon being notified by the staff, he has changed out the bedframe, and hospice will be notified. During an interview on 06/26/2025 at 3:00 PM, Resident #10 expressed her satisfaction with living at the facility. She had no concerns with her room being dirty. She showed the surveyor her new bed that the facility had gotten her. She stated the other one kept slipping off the frame. She stated that she was pleased with the services provided by the staff. She stated that her room is always clean when she was showering. She denied ever seeing gloves or briefs on the floor of her bathroom. She stated that housekeeping staff were cleaning her room and shower, and all staff ensured that her call light was in reach. She stated that she wasn't scared of anyone at the facility nor was she fearful of retaliation. In an observation of Resident #10's room revealed an open carton of milk from breakfast and a bag of pretzels on the nightstand that had not been removed from the room or stored properly. Resident #10's bathroom was clean. Record review of the facility's Incontinent Care/Perineal Care policy, dated December 2018, reflected in part: It is the policy of this home that the Administrator or other appropriate designee completes environmental rounds on a regular basis .Discard soiled gloves, sanitize hands. Re-glove prior to touching clean linens / adult brief .Closing steps: Clean and store reusable items and discard disposables per home guideline If gloved, remove and discard gloves following home guideline at the appropriate time to avoid environmental contamination. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Infection Control Environmental Rounds policy, dated June 2022 reflected: Environment rounds will be an integral part of the daily routine and also will be performed regularly throughout the entire home, with detailed reporting to all units and departments as needed. (It is suggested that a selection of individual units as well as the dietary, laundry, and housekeeping departments be specifically identified for closer scrutiny each month.) .The Administrator / designee will generate reports identifying areas of noncompliance. This report and a corrective action form will be distributed to the supervisors of each area. The corrective action form will be completed by the supervisor and will outline the corrective actions to be taken and the anticipated completion dates Environmental rounds reports will be retained to illustrate the improvement of quality of life within the facility and for review/comparison purposes within the home over a period of time.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for one of one resident (Resident #1) reviewed for abuse, neglect, and exploitation. The facility failed to implement their policies and procedures to ensure Resident #1 was free from neglect when the facility failed to have effective interventions and services in place to address the resident's care, which resulted in Resident #1 sustaining injuries of ICH (intracerebral hemorrhage (type of stroke bleeding on the brain tissue due to a ruptured blood vessel), and a closed displaced intertrochanteric fracture of left femur with routine healing Normocytic anemia (is a complex medical condition involving a broken hip bone that has shifted out of place, along with a type of anemia.) An Immediate Jeopardy (IJ) was identified on 06/24/2025 at 4:30 PM While the Immediate Jeopardy was removed on 06/25/24, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of isolated due to the facility's need to implement and monitor the effectiveness of its corrective systems. The failure could place residents at risk for serious injuries, hospitalization, and death. Findings included: Record review of Resident #1's face sheet dated 06/24/2025 reflected the resident was a [AGE] year-old female admitted on [DATE] with active diagnoses that included unspecified cerebral infarction (stroke), displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, Pain, repeated falls, Major depressive disorder (feeling down), and Vascular dementia unspecified severity without behavioral disturbances, Depression, Alzheimer's, and insomnia. Record review of Resident #1's admission MDS assessment dated [DATE] reflected she had minimal difficulty with hearing, clear speech, understood by others and usually understood other. Resident #1's vision was moderately impaired, and she wore corrective lenses. Resident #1 was assessed as having a BIMS score of 08, indicating she was moderately impaired cognitively. She had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had no impairments with range of motion to her upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was frequently incontinent of bowel and bladder and required substantial/maximal assistance (helper does more than half the effort. (Helper lifts or holds trunk, limbs and provides more than half effort.). Resident #1 scored a 9 on functional abilities for sit to stand and walking 10 ft (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.) Resident #1's fall history on admission MDS reflected that Resident #1 had repeated falls and had fallen with since being admitted . Resident #1 did not sustain any injuries. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's discharge MDS assessment dated [DATE] reflected an unplanned discharge to short term general hospital. Resident #1 was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was frequently incontinent of bowel and bladder. Resident #1's was not receiving any special treatments. The assessment reflected she had fall history. Record review of Resident #1's change in condition MDS assessment dated [DATE] reflected she needed an interpreter, due to preferred language being Spanish . She had minimal difficulty with hearing and had clear speech. Resident #1 was able to communicate needs to others. Resident #1 was assessed as having a BIMS score of 07, indicating she was severely impaired cognitively. She had no mood issues, behaviors of rejecting care 4 to 6 days of care no wandering. Resident #1 had no impairments with range of motion to her upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was always incontinent of bowel and bladder. Active diagnoses dementia, Stroke, Arthritis (crippling in joints), Osteoporosis (fragile bones from aging), displaced intertrochanteric fracture of the left femur, subsequent encounter (displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing,) Vascular dementia unspecified severity without behavioral disturbances, Hip Fracture. Additional diagnoses included Unspecified Sequelae of cerebral infarction (after-effects of a stroke), and repeated falls. Resident #1's was not receiving any special treatments. Assessment reflected she had fall history. Record review of Resident #1's care plan dated 04/15/2025 reflected . The resident has visual and cognitive deficits and needs assistance to pursue activities of choice and Category: created The resident has a /communication problem r/t dementia and primarily Spanish speaking Created: 05/01/2025 .interventions . anticipate needs, ensure availability and functioning of adaptive communication equipment (picture board) ensures safe environment: call light in reach, adequate low glare light, bed in lowest position, wheels locked, avoid isolation .Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed Resident has impaired visual functioning and is at risk for a decreased in ADL's and Injuries Created: 05/01/2025 . Resident has impaired cognitive function/dementia or impaired thought processes r/t DX vascular dementia Created: 05/01/2025 resident requires pain management with opiate medications r/t terminal status and hip FX . Resident requires Hospice as evidenced by terminal illness of: inter-cerebral hemorrhage Edited: 06/09/2025 . Category: Falls Resident had an actual fall r/t poor safety awareness, attempting to transfer self, weakness, HX falls . Do not leave unattended in bathroom .remind resident to use call light to gain assistance with transfers, continue therapy services, Edited: 05/27/2025 Resident has Post-op site on L hip, skin tear to L elbow edited 6/11/2025, Resident has surgical wound to L hip R/T . Edited: 06/24/2025 Resident #1 was at risk of falls, r/t weakness, poor safety awareness, skin tears, bruising. Skin assessment addressed bruising and tears, fall assessment completed. Record review of Resident #1's physician's orders dated 06/08/2025 reflected admit to Hospice for DX of intracerebral Hemorrhage (bleeding) at Bedtime 8:00 PM . Record review of orders dated 06/09/2025 reflected: (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitor edema (swelling caused by fluid) Twice a Day 6:00 AM - 2:00 PM days, 3:00 PM - 10:00 PM evenings .Opiate (A class of drug used to reduce moderate to severe pain) medications use .monitor for s/sx of constipation (trouble having a bowel movement), delirium (confusion), over-sedation (drowsy/sleep), change in mental status (overall functions cognitively, mentally, emotionally), and reduced respirations (breaths) . Pain Assessment Q-Shift using the Numeric (relating to or expressed as a number or numbers.) or PAIN scale Special Instructions: document results Every Shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, Nights 10:00 PM - 06:00 AM . order dated. PT/OT/ST to evaluate and treat if indicated . Record review of Resident #1's MD order dated 06/10/2025 reflected Give 1 tablet; 50 mg zinc (220 mg); amt: 1 tab; oral Once a Day. Record review of Resident #1's MD orders dated 06/12/2025 reflected LLE TTWB due to DTI Every Shift Days 06:00 AM - 2:00 PM evenings, 3:00 PM - 10:00 PM evenings Left hip post OP site: Monitor for s/s infection or dehiscence (medical term, dehiscence refers to the separation or splitting open of a surgical wound or incision that was previously closed) if present notify MD Every Shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, Nights 10:00 PM - 06:00 AM . Record review of Resident #1's MD an order dated 07/08/2025 Other Test: (LEFT Hip X-Ray Unilateral 2-3 V (unilateral radiologic examination of a joint or structure, consisting of 2 to 3 views.) .including pelvis with CD (In a medical context, when you see pelvis with CD it most likely refers to a pelvic CT scan that includes images recorded onto a CD.) Once - One Time 06:00 AM -11:00 PM. Record review of Resident #1's skin assessment note dated 06/10/2025 at 12:23 PM reflected under description (skin tear/Laceration). Record review of Resident #1's progress notes on 04/15/2025 at 10:40 AM by LVN-C reflected Pt was up in w/c reading daily journal in her room. This nurse was informed 10:40 by aid that when she was rounding Pt was attempting to get back in bed self and was caught by the aid before she could hit the floor. Pt was landed on her knees and was put back in bed with the help. Denies pain. ROM TO all ext. ALL parties notified. Fall precautions implemented. Bed in lowest position. encouraged pt to use call light for assistance. Frequent visual monitoring done. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 05/20/2025 at 6:29 PM by RN-S reflected Around 3:40 PM this nurse was aware by CNA that the pt is in the floor. Upon entering the room Resident found on the floor in the bathroom on side lying position, wheelchair is locked next to her. Assisted her back to wheelchair with the help of two person. Vital sign WNL. On assessment noticed small skin tear on It elbow with small amount of blood, dressing done. Notified wound care nurse. alert and orient with her baseline. Vitals WNL. Resident states she fell when transferring from commode to wheelchair herself. Complained of L leg pain, Tylenol 650 mg po given, somewhat effective. NP, DON/ADON notified. RP made aware. Received new order to stat X-ray L Hip from NP. updated on portal. Neuros on progress and within normal limits. Bed in low position. fall precaution maintained. will cont. to monitor. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:12 PM by RN-S reflected that X-ray of hip shows left femoral neck fracture. MD made aware. Called 911 and sent to [hospital]around 10 PM. Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:43 PM by LVN-M reflected Spoke with [family member] directly about situation he states that he is in route to [hospital name] now and okay with mother being sent in ambulance. Record review of Resident #1's nursing progress note dated 06/08/2025 by LVN-A reflected Resident came back from the hospital on a non-emergency transportation on a stretcher and was transferred from stretcher to bed Resident had a fall in the facility and sustained a left hip fracture. Surgery was performed and has stitches on the left hip. Dressing is intact and surgical incision is showing visible signs of any infection or drainage. Resident is admitted on services [Hospice] visited the facility. [Hospice] is do present the DNR paper. Hospice has ordered to continue with the discharge orders. Resident is on day 1/3 of follow up for new medication (Tramadol) 50 mg every 4 hours for pain. Clarification is needed from hospice for delivery of Tramadol since order came from them. Hospice has also ordered Comfort Kit. Dietary is notified of the resident coming back. No complains of pain is voiced by resident. Oral fluids and call light is in easy reach. no paper. Hospice has ordered to continue with the discharge orders. Record review of Resident #1's nursing progress note dated 06/09/2025 at 1:13 PM by ADON reflected Follow up monitoring Day 1 of 3 of Re-admit with DX: L hip FX SX (symptoms) repair. AAOx1-2 (refers to the level of alertness and orientation, specifically indicating that a person is aware of who they are and where they are but may not know the current date and time (A&Ox1) or also what happened to them (A&Ox2). Spanish speaking. Under [hospice name]. Respiratory even and unlabored. No sob noted. No cough congestion noted. L hip surgical incision dressing CDI. Denies pain or any other discomfort at this time, Abdomen soft and non-distended bsx4. appetite fair. [Family member] present at bedside. Incontinent to B&B. Wound on Coccyx. (The small, triangular bone at the very bottom of the spine.) Wound care in progress. Turned and repositioned at regular intervals. call light and bedside table within reach. Bed in lowest position. Fall precautions implemented through the shift. call light within reach. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 06/11/2025 at 7:36 AM by the ADON reflected IDT review regarding skin tear to right elbow, obtained during assisted dressing with hospice aide, resident noted with thin/fragile skin resulting in increased risk of injury, site appears with steri strips intact no s/s infection or pain present, Geri sleeves applied for safety. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress note dated 06/11/2025 10:41 AM by LVN-C reflected Follow up monitoring Day 3 of 3 of Re-admit with DX: L hip FX SX repair. AAOx1-2. Resting in bed with HOB elevated to facilitate easy breathing. Spanish speaking. Under [hospice name]. Resp even and unlabored. No sob noted. No cough congestion noted. L hip surgical incision dressing CDI. Medicated with PRN Tramadol. remains effective. Abdomen soft and non-distended bsx4 (Bowel sounds x 4 quadrants refers to the process of listening to the digestive sounds in all four quadrants of the abdomen) appetite remains poor. D1/3 of new orders of vitamin C, Zinc, House protein, 2.0 supplement, mm with min. Incontinent to B&B. Wound on Coccyx. LLE TTWB r/t DTI. Steri-Strips intact on R elbow. wound care in progress. Off loaded bilateral (in a medical context refers to the process of reducing or removing pressure from the heels on both the right and left sides of the body.) heels when in bed. Turned and repositioned at regular intervals. Ortho appt in am. call light and bedside table within reach. Bed in lowest position. Fall precautions implemented through the shift. call light within reach. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 06/11/2025 at 12:40 PM by the ADON reflected left hip f/u X-ray results received and sent to NP for review NNOs (Neuronal nitric oxide syntheses (NNOS) is an enzyme that produces nitric oxide (NO), a potentially harmful molecule implicated in fetal brain injury under .) obtained, disk received for f/u Ortho appt. Record review of Resident #1's nursing progress notes dated 06/11/2025 at 10:49 AM by the ADON reflected Notified by [family member] of Ortho f/u appt on 6/12/20, f/u X-ray to left hip scheduled for STAT today with CD for appt. tomorrow. Record review of Resident #1's nursing progress notes dated 06/12/2025 at 1:52 PM by the ADON reflected Returned from Ortho appt, staples DC' D steri strips in place, LOTA, TX orders updated. Record review of Resident #1's nursing progress notes dated 06/12/2025 05:11 AM by the ADON reflected (L) hip FX sx repair; surgical dressings on L leg kept CDI; resident slept during shift with respirations even and unlabored. Day 2/3 F/U 2.0 suppository 90 cc TID, house protein 30 cc PO BID, Vit C, Zinc, and MVM with min and skin tear with steri strips. LLE TTWB r/t DTI to (L) heel; no complaints from resident at this time. Bed in low position with call light attached. Record review of Resident #1's nursing progress notes 06/23/2025 at 3:49 AM by LVN-C reflected resident with Steri-Strips to L Hip. LLE TTWB R/T DTI to L heel. Offload bilateral heels while in bed (in a medical context refers to the process of reducing or removing pressure from the heels on both the right and left sides of the body.). No c/o pain. Call-light within reach. Record review of Resident #1's nursing progress notes 06/23/2025 at 10:22 PM by LVN-C reflected Resident with Steri-Strips to L Hip. LLE TTWB R/T DTI to L heel. Offload bilatateral heels while in bed. No c/o pain. Call-light within reach. Record review of Resident #1 event note dated 06/10/25 at 12:23 PM by the ADON reflected IDT review: witnessed: no injuries: skin tear right elbow sent to ER: not indicated all parties aware: yes intervention: Geri sleeves BUE HX of similar events: Physician notified at 10:30 AM, Resident Representative notified at 12:27 PM, Care plan revised. (continued on next page)

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	676127	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Hills Rehabilitation and Healthcare Center	5600 Davis Blvd North Richland Hills, TX 76180

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 10:15 AM with the ADMIN, revealed that he was familiar with the incident involving Resident #1. The ADMIN stated the incident occurred on 05/20/2025 and he did not investigate or submit a self-report for the incident. The ADMIN said he did not have the staff write a statement detailing the incident, however, he would check for a written statement. The ADMIN was asked to provide names of the staff involved, daily schedules of the staff with their full name documented for the day of the incident, and an employee roster. The ADMIN stated that there were two aides involved and he would provide their names. The ADMIN stated the CNA-F placed resident on the toilet, then told CNA-J that Resident #1 was left on the toilet and follow up with checks on the resident. The ADMIN stated that Resident #1 was left on the toilet for 5 minutes. The ADMIN stated they requested privacy and waived her hand for CNA-F to leave the bathroom. The ADMIN said after 5 minutes had passed CNA-F returned to Resident #1's room to check on her and heard her fall. The ADMIN said CNA-F called out for CNA-J to come and help with the resident to transfer her off the bathroom floor. The ADMIN stated that RN-S assessed Resident #1 and notified the MD, ADMIN, ADON, RNC, and POA. The MD ordered X-rays immediately. The ADMIN stated once the X-ray results were reviewed by the MD, EMS was called, and she was transported to the hospital emergency room. The ADMIN said Resident #1 returned from the hospital with hospice services and assessments for therapy. The ADMIN stated that the facility did not have a DON currently and the RNC and ADON were in charge of the nursing department. The ADMIN stated that the RNC was not at the facility at this time. He stated that the resident requested privacy from the CNA -F and it was granted. During an interview on 06/24/2025 at 10:25 AM the ADON stated that the hospital records located in the Resident #1's clinical file to review. The ADON stated that the POA was notified and later visited Resident #1. The ADON stated that Resident #1 received immediate care after her fall by RN-S and CNA-F. She said Resident #1 had a skin tear to her left elbow. She said RN-S assessed Resident #1, notified the on-call nurse, RNC, ADON, and POA. ADON said the MD ordered immediate X-rays for the resident. The ADON said once the X-ray result was reviewed by the MD, Resident #1 was sent out via emergency transport to the hospital, where it was later confirmed she had a fractured hip. The ADON said hospice services were ordered upon her return to the facility on [DATE]. The ADON stated Resident #1 had a previous fall incident and almost fell, but a CNA (name unknown), was present and prevented the fall. The ADON stated that Resident #1 was assessed, and the facility recorded the incident and followed the fall protocol. The ADON said Resident #1 was assessed for falls, the care plan was updated, and she was placed on 72-hour post fall observation and monitoring as a precaution on 04/15/2025. On 06/24/2025 at 10:30 AM, the ADON provided the names of the staff involved without contact information. During and observation and interview of on 06/24/2025 at 11:13 AM Resident #1, revealed she was Spanish speaking with some English. Resident #1 said she did not know how she fell and did not remember. She stated that she did not know how to use the call light. Resident #1 was lying in bed; a fall mat was next to bed and the call light was in reach. Upon further observation Resident #1's communication board/picture board was not in the room. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 11:15 AM with the FM, she stated that Resident #1 had dementia and could not use the call light. The FM stated that Resident #1 was unable to use the call light, due to her dementia. FM said Resident #1 required total assistance from staff. The FM said Resident #1 had a communication/picture board for communication. FM said she searched for Resident #1's communication picture board, and it was not in her room. The FM said upon returning to the facility she and the POA installed a video camera to supervise and communicate with Resident #1. The FM said she and the POA had not observed the staff utilizing the picture board to communicate with Resident #1 since returning to the facility on [DATE]. The FM said Resident #1 could respond to some questions, but the picture board was implemented by the facility to assist with communicating her needs to the staff. FM said she later found out by the POA that the communication board sent home at the time of discharge to the hospital. The FM said Resident #1 had declined significantly, she is bed bound most of the day, and receives hospice care due to bleeding on the brain from the fall 05/20/2025. During a phone interview on 06/24/2025 at 11:51 AM with the POA, the POA stated that he received a call from the facility that Resident #1 had fell in the bathroom and the MD ordered X rays. The POA said he arrived at the facility on 05/20/2025 an hour after the call (exact time unknown) and observed 1 shoe of Resident #1 and blood still on the bathroom floor from Resident #1's fall. The POA said Resident #1 could not use the call light, despite ongoing education by the staff, FM, and POA. The POA said Resident #1 was a fall risk from a previous fall in April 2025. The POA said Resident #1 should have never been left on the toilet alone. The POA said the staff were not using the picture board to communicate with Resident #1. The POA said he believes Resident #1 was left alone on the toilet for more than 5 minutes, causing the fall and injuries on 05/20/2025. The POA said after the fall he installed a camera and communicates with Resident #1 via camera. The POA said the staff assigned was aware of Resident #1's needs to be supervised due to falls, yet she left Resident #1 on the toilet unsupervised. The POA said he has observed staff taking 25 minutes to take Resident #1 to the bathroom, then leave the resident alone. POA said Resident #1 was not able to ask for privacy from the staff due to her cognitive decline. The POA said he does not believe that the staff were near the bathroom when Resident #1 fell. POA said he does not know the name of the staff that was working. POA said upon arrival to the hospital he was told that Resident #1 had a femur and hip fracture on the left side, skin tears to the left elbow, bleeding on the brain, and was being monitored. POA said the hospital conducted surgery to repair Resident #1's hip. POA said Resident #1's mental acuteness (awareness) had diminished since the fall. POA said Resident #1 was admitted to the facility to receive care, and now that she fell and was hospitalized , she requires total staff assistance. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/24/2025 at 2:10 PM with CNA-F, revealed as she was walking past Resident #1's room she observed the resident trying to get out of bed independently. She went to assist the resident, and she could not understand her response and what she was saying, because the resident was speaking in Spanish. CNA-F said she called CNA-J (a Spanish speaking employee) to communicate Resident #1's needs. CNA-J told CNA-F that Resident #1 wanted to put her pajamas on for bed. CNA-F said once Resident #1 was dressed, she returned the resident to sit in her wheelchair, and she attempted to get out of the chair. CNA-F said she assumed Resident #1 wanted to go to the bathroom, so she assisted. CNA-F said Resident #1 was transferred to the toilet in her bathroom. CNA-F said she remained in the bathroom initially, until Resident #1 gestured with her hand to leave the restroom. CNA-F said she notified CNA-J caring for a patient in another room, that Resident #1 was on the toilet, and to check on her while she resumed care of another resident. CNA-F said about 2 to 3 minutes later as she was walking down the hall, she remembered Resident #1 was on the toilet. CNA-F said as she entered the room, she heard Resident #1 fall. She immediately called RN-S for help. CNA-F said the fall was unwitnessed, and did not think Resident #1 hit her head. CNA-F said Resident #1 was bleeding from her left elbow. CNA- F said Resident #1 was in pain. CNA-F said she did not observe any other injuries, lumps, or bruising to the head. She was in pain. CNA-F said Resident #1 was talking and answering the nurse's questions and responding. CNA-F said she was not familiar with Resident #1's clinical needs nor could she speak Spanish. CNF-A said she did not know that Resident #1 was a fall risk and could not be left alone in the bathroom. She said this was a one-time incident and she gave the resident privacy. During an interview on 06/24/2025 at 2:15 PM with RN-S, revealed she had been working at the facility for 9 months. RN S stated that she was familiar with Resident #1's care and knew that she was a fall risk. RN-S said she worked the day of Resident #1's fall, 05/20/2025. RN-S said CNA-F called for her assistance with a resident that fell, so she immediately responded to the room. RN-S said Resident #1 was found lying on the floor in the bathroom on her left side with a skin tear to the left elbow. RN-S said the resident was alert and communicating with her and she did not lose consciousness. RN-S said the resident understood English and Spanish. RN-S and CNA-F assisted Resident #1 to the wheelchair. RN-S said she called the MD and the on-call nurse to report the incident. RN-S stated that the MD ordered immediate Xray's. RN-S notified the POA, and he wanted to delay sending Resident #1 to the hospital, and she explained that the facility policy was to provide immediate care and transport to the hospital for further assessment of the injuries. RN-S said she gave her Tylenol for pain at 6:25 PM. RN-S said the portable X-ray technician arrived 9:00 PM. RN-S said once the X-ray's were reviewed by the MD resident was sent to the hospital. RN-S said Resident #1's base line prior to fall included providing assistance to stand, eat, and all care. RN-S denied knowledge of Resident #1 having a picture board to communicate with staff. RN-S said Resident #1's cognition was the same after the fall, she had not observed any changes. RN-S said Resident #1 used non-verbal signals to communicate and she could answer yes and no to most questions. She said she was aware that Resident #1 was a fall risk. RN-S said Resident #1 should not be left alone, due to a history of falls and decline in cognition. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 2:38 PM with CNA-J revealed she had placed Resident 1# in bed and proceeded to assist another resident with care. CNA-J said CNA-F did not tell her that the resident was in the bathroom on the toilet and to monitor. CNA-J stated that Resident #1 requires assistance from the staff with transfers and she could not self-transfer or ambulate. CNA-J said she would not have left Resident #1 unsupervised or alone in the bathroom, due to her diagnosis of Dementia and increased confusion. CNA-J said Resident #1 communicate in Spanish and say yes and no. She does not know how long CNA-F left Resident #1 on the toilet. CNA-J was told about the incident later that evening. CNA-J said CNA-F and the nurse responded to the fall. CNA-J said residents should never be left alone on the toilet, because a frequent movement could result in a fall. During an interview on 06/24/2025 at 5:00 PM with the ADMIN, revealed that that CNA-F notified CNA J to monitor Resident #1 on the toilet. The ADMIN insisted that the resident was being monitored by CNA-J and had been left for 2 to 3 minutes. The ADMIN stated that Resident #1 was a fall risk at her bedside, not in the bathroom, and she had a right to request privacy. The ADMIN said any resident could fall from the toilet and have injuries. The ADMIN returned at 5:34 PM and stated that he was not sure if he had statements, and he had to investigate further because CNA-J's and CNA-F's stories were not adding up. The surveyor stated that in the interview with CNA-F, she stated that the nurse was immediately notified not CNA-J. The ADMIN stated that he may have confused the staff statements with notification of help when Resident #1 fell. During another interview with the ADON on 06/24/2025 at 6:09 PM with the ADON she stated that the resident could use the call light prior to the fall. The surveyor explained that the resident stated she did not know how to use the call light this morning during an interview. The ADON stated that she could before the fall now she couldn't. The ADON was asked about the communication board that was care planned to communicate with the staff. She said she did not know where it was. The surveyor told her the FM stated that the board was sent home upon her discharge to hospital on 5/20/25. She said if they picked the communication board up and did not return, there was nothing she could do. She stated the resident could not communicate. The surveyor asked if pictures of tasks were documented on the board, and she said yes. The surveyor asked if the communication board was care planned currently, she said yes. During an interview with the ADMIN on 06/25/2025 at 12:10 PM he stated that he did not submit a self-report to HHS about the incident, however, he completed the investigation on 05/26/25. Record review of CNA-F written statement dated 5/20/25 (provided by the ADMIN on 06/24/2025 at 5:50 PM ADMIN) reflected CNA-F did not seek further assistance from anyone, and while she was attending to another task, Resident #1 may have been unsupervised longer than 1 to 3 minutes. During a second interview on 06/26/2025 at 11:02 AM the PO, stated that Resident #1 was not able to verbalize how she fell after being asked several times by him, the FM, and the staff. The POA denied hearing Resident #1 say what happened on 05/20/2025, and he never translated or communicated a statement from Resident #1 to the ADMIN or staff at the facility about the fall. During a second interview with the FM on 06/30/2025 at 11:40 AM, she stated that Resident #1 was unable to communicate what happened with the fall, due to her dementia, and injuries after the fall. She stated that she had asked Resident #1 on multiple occasions with the POA, and she couldn't recall what occurred. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility investigation completed by the ADMIN on 05/26/2025 revealed investigation report Subject: Incident Involving Resident #1 - Bathroom Fall Resulting in Hip Fracture Resident Information: Name: [Resident # 1] Date of Incident: May 20, 2025, Date Reported: May 20, 2025, Cognitive Status: BIM's Score - 8 Primary Language: Spanish and speaks some English. Incident Summary: On May 20, 2025, I, [ADMIN] LNFA, was notified of an X-ray result confirming that Resident # 1 sustained a fractured hip following a fall in the bathroom. Upon notification, I immediately contacted [name] ADON, and [name] ADON-T, to begin reviewing the details of the incident. Narrative of Events: According to documentation and staff interviews: o [CNA-F] escorted [Resident #1] to the restroom. o The resident requested privacy by verbally dismissing CNA-[CNA-F] and pointing to the call light cord, indicating she understood how to call for assistance. [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury to the administrator of the facility and to other officials including to the State Agency in accordance with State law through established procedures, for one of one resident (Resident #1) reviewed for abuse, neglect and exploitation . The facility failed to report to the state agency when Resident #1 was left unattended in the bathroom and fell sustaining injuries of a fractured femur and fractured left hip. Additionally, the resident was ordered hospice due to another diagnosis of ICH (intracerebral hemorrhage), which is atype of stroke bleeding on the brain tissue due to a ruptured blood vessel. Findings included: Record review of Resident #1's face sheet dated 06/24/2025 reflected the resident was a [AGE] year-old female admitted on [DATE] with active diagnoses that included unspecified cerebral infarction (stroke), displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, Pain, repeated falls, Major depressive disorder (feeling down), and Vascular dementia unspecified severity without behavioral disturbances, Depression, Alzheimer's, and insomnia. Record review of Resident #1's admission MDS assessment dated [DATE] reflected she had minimal difficulty with hearing, clear speech, understood by others and usually understood other. Resident #1's vision was moderately impaired, and she wore corrective lenses. Resident #1 was assessed as having a BIMS score of 08, indicating she was moderately impaired cognitively. She had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had no impairments with range of motion to her upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was frequently incontinent of bowel and bladder and required substantial/maximal assistance (helper does more than half the effort. (Helper lifts or holds trunk, limbs and provides more than half effort.). Resident #1 scored a 9 on functional abilities for sit to stand and walking 10 ft (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.). Resident #1's fall history on admission MDS reflected that Resident #1 had repeated falls and had fallen with since being admitted . Resident #1 did not sustain any injuries. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 04/15/2025 reflected . The resident has visual and cognitive deficits and needs assistance to pursue activities of choice and Category: created The resident has a /communication problem r/t dementia and primarily Spanish speaking Created: 05/01/2025 .interventions . anticipate needs, ensure availability and functioning of adaptive communication equipment (picture board) ensures safe environment: call light in reach, adequate low glare light, bed in lowest position, wheels locked, avoid isolation .Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed Resident has impaired visual functioning and is at risk for a decreased in ADL's and Injuries Created: 05/01/2025 . Resident has impaired cognitive function/dementia or impaired thought processes r/t DX vascular dementia Created: 05/01/2025 resident requires pain management with opiate medications r/t terminal status and hip FX . Resident requires Hospice as evidenced by terminal illness of: inter-cerebral hemorrhage Edited: 06/09/2025 . Category: Falls Resident had an actual fall r/t poor safety awareness, attempting to transfer self, weakness, HX falls . Do not leave unattended in bathroom .remind resident to use call light to gain assistance with transfers, continue therapy services, Edited: 05/27/2025 Resident has Post-op site on L hip, skin tear to L elbow edited 6/11/2025, Resident has surgical wound to L hip R/T . Edited: 06/24/2025 Resident #1 was at risk of falls, r/t weakness, poor safety awareness, skin tears, bruising. Skin assessment addressed bruising and tears, fall assessment completed. Record review of Resident #1's MD orders dated 06/12/2025 reflected LLE TTWB due to DTI Every Shift Days 06:00 AM - 2:00 PM evenings, 3:00 PM - 10:00 PM evenings Left hip post OP site: Monitor for s/s infection or dehiscence (medical term, dehiscence refers to the separation or splitting open of a surgical wound or incision that was previously closed) if present notify MD Every Shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, Nights 10:00 PM - 06:00 AM . Record review of Resident #1's MD an order dated 07/08/2025 Other Test: (LEFT Hip X-Ray Unilateral 2-3 V (unilateral radiologic examination of a joint or structure, consisting of 2 to 3 views.) .including pelvis with CD (In a medical context, when you see pelvis with CD it most likely refers to a pelvic CT scan that includes images recorded onto a CD.) Once - One Time 06:00 AM -11:00 PM. Record review of Resident #1's skin assessment note dated 06/10/2025 at 12:23 PM reflected under description (skin tear/Laceration). Record review of Resident #1's nursing progress note dated 05/20/2025 at 6:29 PM by RN-S reflected Around 3:40 PM this nurse was aware by CNA that the pt is in the floor. Upon entering the room Resident found on the floor in the bathroom on side lying position, wheelchair is locked next to her. Assisted her back to wheelchair with the help of two person. Vital sign WNL. On assessment noticed small skin tear on lt elbow with small amount of blood, dressing done. Notified wound care nurse. alert and orient with her baseline. Vitals WNL. Resident states she fell when transferring from commode to wheelchair herself. Complained of L leg pain, Tylenol 650 mg P O given, somewhat effective. NP, DON/ADON notified. RP made aware. Received new order to stat X-ray L Hip from NP. updated on portal. Neuros on progress and within normal limits. Bed in low position. fall precaution maintained. will cont. to monitor. Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:12 PM by RN-S reflected that X-ray of hip shows left femoral neck fracture. MD made aware. Called 911 and sent to [hospital]around 10 PM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:43 PM by LVN-M reflected Spoke with [family member] directly about situation he states that he is in route to [hospital name] now and okay with mother being sent in ambulance. During an interview on 06/24/2025 at 10:15 AM with the ADMIN, that on 05/20/2025 Resident #1 fell in the bathroom. ADMIN said she was left unattended by CNA-F when Resident #1 requested privacy. The ADMIN stated that RN-S assessed Resident #1 and notified the MD, ADMIN, ADON, RNC, and POA. The MD ordered X-rays immediately. The ADMIN stated once the X-ray results were reviewed by the MD, EMS was called, and she was transported to the hospital emergency room. The ADMIN said Resident #1 returned from the hospital with hospice services and assessments for therapy. The ADMIN stated that he did not investigate or submit a self-report for the incident. The ADMIN said he did not have the staff write a statement detailing the incident, however, he would search for a written statement. During an interview on 06/24/2025 at 10:25 AM the ADON stated that Resident #1 fell off the toilet when CNA-F left her unattended and returned to find the floor. She said Resident #1 had a skin tear to her left elbow. She CNA-F notified the charge nurse RN-S of the fall. She said RN-S assessed Resident #1, notified the on-call nurse, RNC, ADON, and POA. ADON said the MD ordered immediate X-rays for the resident. The ADON said once the X-ray result was reviewed by the MD, Resident #1 was sent out via emergency transport to the hospital, where it was later confirmed she had a fractured hip. The ADON said hospice services were ordered upon her return to the facility on [DATE]. The ADON said that the ADMIN was notified of the incident immediately. The ADON said Resident #1 was assessed for falls, the care plan was updated, and she was placed on 72-hour post fall observation and monitoring as a precaution on 04/15/2025. On 06/24/2025 at 10:30 AM, the ADON provided the names of the staff involved without contact information. During and observation and interview of on 06/24/2025 at 11:13 AM Resident #1, revealed she was Spanish speaking with some English. Resident #1 said she did not know how she fell and did not remember. She stated that she did not know how to use the call light. Resident #1 was lying in bed; a fall mat was next to bed and the call light was in reach. Upon further observation Resident #1's communication board/picture board was not in the room. During a phone interview on 06/24/2025 at 2:10 PM with CNA-F, revealed as she was walking past Resident #1's room she observed the resident trying to get out of bed independently. She went to assist the resident, and she could not understand her response and what she was saying, because the resident was speaking in Spanish. CNA-F said she called CNA-J (a Spanish speaking employee) to communicate Resident #1's needs. CNA-J told CNA-F that Resident #1 wanted to put her pajamas on for bed. CNA-F said once Resident #1 was dressed, she returned the resident to sit in her wheelchair, and she attempted to get out of the chair. CNA-F said she assumed Resident #1 wanted to go to the bathroom, so she assisted. CNA-F said Resident #1 was transferred to the toilet in her bathroom. CNA-F said she remained in the bathroom initially, until Resident #1 gestured with her hand to leave the restroom. CNA-F said she notified CNA-J caring for a patient in another room, that Resident #1 was on the toilet, and to check on her while she resumed care of another resident. CNA-F said about 2 to 3 minutes later as she was walking down the hall, she remembered Resident #1 was on the toilet. CNA-F said as she entered the room, she heard Resident #1 fall. She immediately called RN-S for help. CNA-F said the fall was unwitnessed. CNA-F said she was not familiar with Resident #1's clinical needs, nor could she speak Spanish. CNF-A said she did not know that Resident #1 was a fall risk and could not be left alone in the bathroom. She said this was a one-time incident and she gave the resident privacy. (continued on next page)

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Emerald Hills Rehabilitation and Healthcare Center	5600 Davis Blvd North Richland Hills, TX 76180

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/2025 at 2:15 PM with RN-S, revealed on 05/20/2025 CNA-F called for her assistance with a resident that fell, so she immediately responded to the room. RN-S said Resident #1 was found lying on the floor in the bathroom on her left side with a skin tear to the left elbow. RN-S said the resident was alert and communicating with her and she did not lose consciousness. RN-S said the resident understood English and Spanish. RN-S and CNA-F assisted Resident #1 to the wheelchair. RN-S said she called the MD and the on-call nurse to report the incident. RN-S stated that the MD ordered immediate Xray's. RN-S notified the POA, and he wanted to delay sending Resident #1 to the hospital, and she explained that the facility policy was to provide immediate care and transport to the hospital for further assessment of the injuries. RN-S said she gave her Tylenol for pain at 6:25 PM. RN-S said the portable X-ray technician arrived 9:00 PM. RN-S said once the X-rays were reviewed by the MD resident was sent to the hospital. RN-S denied knowledge of Resident #1 having a picture board to communicate with staff. She said she was aware that Resident #1 was a fall risk. RN-S said Resident #1 should not be left alone, due to a history of falls and decline in cognition. During an interview on 06/24/2025 at 2:38 PM with CNA-J revealed she had placed Resident 1# in bed and proceeded to assist another resident with care. CNA-J said CNA-F did not tell her that the resident was in the bathroom on the toilet and to monitor. CNA-J stated that Resident #1 requires assistance from the staff with transfers and she could not self-transfer or ambulate. CNA-J said she would not have left Resident #1 unsupervised or alone in the bathroom, due to her diagnosis of Dementia and increased confusion. CNA-J said Resident #1 communicate in Spanish and say yes and no. She does not know how long CNA-F left Resident #1 on the toilet. CNA-J was told about the incident later that evening. CNA-J said CNA-F and the nurse responded to the fall. CNA-J said residents should never be left alone on the toilet, because a frequent movement could result in a fall. During an interview on 06/24/2025 at 5:00 PM with the ADMIN, revealed that that CNA-F notified CNA J to monitor Resident #1 on the toilet. The ADMIN insisted that the resident was being monitored by CNA-J and had been left for 2 to 3 minutes. The ADMIN stated that Resident #1 was a fall risk at her bedside, not in the bathroom, and she had a right to request privacy. The ADMIN said any resident could fall from the toilet and have injuries. The ADMIN returned at 5:34 PM and stated that he was not sure if he had statements, and he had to investigate further because CNA-J's and CNA-F's stories were not adding up. The surveyor stated that in the interview with CNA-F, she stated that the nurse was immediately notified not CNA-J. The ADMIN stated that he may have confused the staff statements with notification of help when Resident #1 fell. During another interview with the ADON on 06/24/2025 at 6:09 PM with the ADON she stated that the resident could use the call light prior to the fall. The surveyor explained that the resident stated she did not know how to use the call light this morning during an interview. The ADON stated that she could before the fall now she couldn't. The ADON was asked about the communication board that was care planned to communicate with the staff. She said she did not know where it was. The surveyor told her the FM stated that the board was sent home upon her discharge to hospital on 5/20/25. She said if they picked the communication board up and did not return, there was nothing she could do. She stated the resident could not communicate. The surveyor asked if pictures of tasks were documented on the board, and she said yes. The surveyor asked if the communication board was care planned. During an interview with the ADMIN on 06/25/2025 at 12:10 PM he stated that he did not submit a self-report to HHS about the incident, however, he completed the investigation on 05/26/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second interview on 06/26/2025 at 11:02 AM the POA, stated that Resident #1 was not able to verbalize how she fell after being asked several times by him, the FM, and the staff. The POA denied hearing Resident #1 say what happened on 05/20/2025, and he never translated or communicated a statement from Resident #1 to the ADMIN or staff at the facility about the fall. During a second interview with the FM on 06/30/2025 at 11:40 AM, she stated that Resident #1 was unable to communicate what happened with the fall, due to her dementia, and injuries after the fall. She stated that she had asked Resident #1 on multiple occasions with the POA, and she couldn't recall what occurred. Record review of CNA-F written statement dated 5/20/25 (provided by the ADMIN on 06/24/2025 at 5:50 PM ADMIN) reflected CNA-F did not seek further assistance from anyone, and while she was attending to another task, Resident #1 may have been unsupervised longer than 1 to 3 minutes. Record review of facility investigation completed by the ADMIN on 05/26/2025 revealed investigation report Subject: Incident Involving Resident #1 - Bathroom Fall Resulting in Hip Fracture Resident Information: Name: [Resident # 1] Date of Incident: May 20, 2025, Date Reported: May 20, 2025, Cognitive Status: BIM's Score - 8 Primary Language: Spanish and speaks some English. Incident Summary: On May 20, 2025, I, [ADMIN] LNFA, was notified of an X-ray result confirming that Resident # 1 sustained a fractured hip following a fall in the bathroom. Upon notification, I immediately contacted [name] ADON, and [name] ADON-T, to begin reviewing the details of the incident. Narrative of Events: According to documentation and staff interviews: o [CNA-F] escorted [Resident #1] to the restroom. o the resident requested privacy by verbally dismissing CNA-[CNA-F] and pointing to the call light cord, indicating she understood how to call for assistance. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o [Resident #1] has a BIMS of 8, suggesting moderate cognitive impairment, but she has consistently demonstrated the ability to use the call light independently and not have unsteady gate when sitting on the toilet or chair. o CNA- [CNA-F] stepped out of the room and informed [CNA-J] verbally to check on the resident in a bit. o During my follow-up with [CNA-J], she stated she did not hear the instruction from [CNA-F.] o [CNA-F] tended to another resident and, noticing [CNA-J] had not yet checked on [Resident #1], went back to the room within a three to four minutes. o as [CNA-F] approached the bathroom, she heard [Resident #1] fall and immediately entered to assist. Resident Statement: When asked by staff about what happened, [Resident #1] clearly stated she attempted to stand and transfer herself to her wheelchair, which led to her fall. Her [POA], [Resident #], who serves as her Spanish-language translator, confirmed this account, and reiterated it to me directly during a phone conversation on May 21, 2025. Communication and Reporting: o I spoke directly with [CNA-F], [CNA-J], and both ADONs to gather a complete account of the incident. o Following this, I consulted with [RDOA], Regional Director of Operations, and [RNC] RN, Regional Nurse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o It was determined that this incident does not meet the criteria for state reporting, as: o the resident requested privacy and had the cognitive and physical history of using the call light. o the resident explained what occurred and accepted responsibility for her attempt to transfer independently. o the resident was heard clearly by the CNA (did not specify which CNA) falling and the area was free of any hazards. o the resident was safe to be left on the toilet per her care status at the time. Care Plan & Follow-Up: As a preventive measure, I directed the Nursing team to update [Resident #1's] care plan to reflect that she should not be left alone while on the toilet moving forward, regardless of her ability to use the call light. Additionally, I maintained frequent communication with [POA], providing updates via phone and text to ensure transparency and family involvement in her care. Conclusion: This incident was thoroughly reviewed, and all appropriate internal and regional parties were consulted. While unfortunate, the [Resident #1's] own actions contributed to the fall, and steps have been taken to enhance her safety and prevent recurrence. Record Review of the ADMIN's in-service document reflected in-service 6/25/25.Residents designated as a fall risk will be identified in POC under the resident's profile. Residents identified as fall risk are not to be left unattended on the toilet unless otherwise care planned Communication boards are to be kept at bedside and utilized per plan of care if applicable for residents with communication deficit. If residents observed with difficulty communicating notify nurse management for communication board if one is not already in place 1, instructor: [RNC]. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Abuse reportable events dated 12/01/2018 reflected in part Policy: All residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide and ensure the promotion and protection of resident rights. It is everyone's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility Neglect: is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress Training: The facility will train through orientation and on-going in-services on issues related to abuse/neglect prohibition practices regularly .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received adequate supervision and assistive devices to prevent accidents for 1 resident of 8 residents (Resident #1) reviewed for assistive devices and supervision. The facility failed to ensure Resident #1 received adequate supervision and care in accordance with professional standards when the resident was left attended on the toilet resulting in her falling and sustaining fractures to the Femur and left Hip. Additional injuries included ICH (intracerebral hemorrhage (type of stroke bleeding on the brain tissue due to a ruptured blood vessel), Normocytic anemia (is a complex medical condition involving a broken hip bone that has shifted out of place, along with a type of anemia.) An Immediate Jeopardy (IJ) was identified on 06/24/2025 at 4:30 PM While the Immediate Jeopardy was removed on 06/25/24, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of isolated due to the facility's need to implement and monitor the effectiveness of its corrective systems. The failure could place residents at risk for serious injuries, hospitalization, and death. Findings included: Record review of Resident #1's face sheet dated 06/24/2025 reflected the resident was a [AGE] year-old female admitted on [DATE] with active diagnoses that included unspecified cerebral infarction (stroke), displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, Pain, repeated falls, Major depressive disorder (feeling down), and Vascular dementia unspecified severity without behavioral disturbances, Depression, Alzheimer's, and insomnia. Record review of Resident #1's admission MDS assessment dated [DATE] reflected she had minimal difficulty with hearing, clear speech, understood by others and usually understood other. Resident #1's vision was moderately impaired, and she wore corrective lenses. Resident #1 was assessed as having a BIMS score of 08, indicating she was moderately impaired cognitively. She had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had no impairments with range of motion to her upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was frequently incontinent of bowel and bladder and required substantial/maximal assistance (helper does more than half the effort. (Helper lifts or holds trunk, limbs and provides more than half effort.). Resident #1 scored a 9 on functional abilities for sit to stand and walking 10 ft (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.) Resident #1's fall history on admission MDS reflected that Resident #1 had repeated falls and had fallen with since being admitted . Resident #1 did not sustain any injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's discharge MDS assessment dated [DATE] reflected an unplanned discharge to short term general hospital. Resident #1 was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was frequently incontinent of bowel and bladder. Resident #1's was not receiving any special treatments. The assessment reflected she had fall history. Record review of Resident #1's change in condition MDS assessment dated [DATE] reflected she needed an interpreter, due to preferred language being Spanish . She had minimal difficulty with hearing and had clear speech. Resident #1 was able to communicate needs to others. Resident #1 was assessed as having a BIMS score of 07, indicating she was severely impaired cognitively. She had no mood issues, behaviors of rejecting care 4 to 6 days of care no wandering. Resident #1 had no impairments with range of motion to her upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was always incontinent of bowel and bladder. Active diagnoses dementia, Stroke, Arthritis (crippling in joints), Osteoporosis (fragile bones from aging), displaced intertrochanteric fracture of the left femur, subsequent encounter (displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing,) Vascular dementia unspecified severity without behavioral disturbances, Hip Fracture. Additional diagnoses included Unspecified Sequelae of cerebral infarction (after-effects of a stroke), and repeated falls. Resident #1's was not receiving any special treatments. Assessment reflected she had fall history. Record review of Resident #1's care plan dated 04/15/2025 reflected . The resident has visual and cognitive deficits and needs assistance to pursue activities of choice and Category: created The resident has a /communication problem r/t dementia and primarily Spanish speaking Created: 05/01/2025 .interventions . anticipate needs, ensure availability and functioning of adaptive communication equipment (picture board) ensures safe environment: call light in reach, adequate low glare light, bed in lowest position, wheels locked, avoid isolation .Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed Resident has impaired visual functioning and is at risk for a decreased in ADL's and Injuries Created: 05/01/2025 . Resident has impaired cognitive function/dementia or impaired thought processes r/t DX vascular dementia Created: 05/01/2025 resident requires pain management with opiate medications r/t terminal status and hip FX . Resident requires Hospice as evidenced by terminal illness of: inter-cerebral hemorrhage Edited: 06/09/2025 . Category: Falls Resident had an actual fall r/t poor safety awareness, attempting to transfer self, weakness, HX falls . Do not leave unattended in bathroom .remind resident to use call light to gain assistance with transfers, continue therapy services, Edited: 05/27/2025 Resident has Post-op site on L hip, skin tear to L elbow edited 6/11/2025, Resident has surgical wound to L hip R/T . Edited: 06/24/2025 Resident #1 was at risk of falls, r/t weakness, poor safety awareness, skin tears, bruising. Skin assessment addressed bruising and tears, fall assessment completed. Record review of Resident #1's physician's orders dated 06/08/2025 reflected admit to Hospice for DX of intracerebral Hemorrhage (bleeding) at Bedtime 8:00 PM . Record review of orders dated 06/09/2025 reflected: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitor edema (swelling caused by fluid) Twice a Day 6:00 AM - 2:00 PM days, 3:00 PM - 10:00 PM evenings .Opiate (A class of drug used to reduce moderate to severe pain) medications use .monitor for s/sx of constipation (trouble having a bowel movement), delirium (confusion), over-sedation (drowsy/sleep), change in mental status (overall functions cognitively, mentally, emotionally), and reduced respirations (breaths) . Pain Assessment Q-Shift using the Numeric (relating to or expressed as a number or numbers.) or PAIN scale Special Instructions: document results Every Shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, Nights 10:00 PM - 06:00 AM . order dated. PT/OT/ST to evaluate and treat if indicated . Record review of Resident #1's MD order dated 06/10/2025 reflected Give 1 tablet; 50 mg zinc (220 mg); amt: 1 tab; oral Once a Day. Record review of Resident #1's MD orders dated 06/12/2025 reflected LLE TTWB due to DTI Every Shift Days 06:00 AM - 2:00 PM evenings, 3:00 PM - 10:00 PM evenings Left hip post OP site: Monitor for s/s infection or dehiscence (medical term, dehiscence refers to the separation or splitting open of a surgical wound or incision that was previously closed) if present notify MD Every Shift Days 6:00 AM - 2:00 PM, Evenings 2:00 PM - 10:00 PM, Nights 10:00 PM - 06:00 AM . Record review of Resident #1's MD an order dated 07/08/2025 Other Test: (LEFT Hip X-Ray Unilateral 2-3 V (unilateral radiologic examination of a joint or structure, consisting of 2 to 3 views.) .including pelvis with CD (In a medical context, when you see pelvis with CD it most likely refers to a pelvic CT scan that includes images recorded onto a CD.) Once - One Time 06:00 AM -11:00 PM. Record review of Resident #1's skin assessment note dated 06/10/2025 at 12:23 PM reflected under description (skin tear/Laceration). Record review of Resident #1's progress notes on 04/15/2025 at 10:40 AM by LVN-C reflected Pt was up in w/c reading daily journal in her room. This nurse was informed 10:40 by aid that when she was rounding Pt was attempting to get back in bed self and was caught by the aid before she could hit the floor. Pt was landed on her knees and was put back in bed with the help. Denies pain. ROM TO all ext. ALL parties notified. Fall precautions implemented. Bed in lowest position. encouraged pt to use call light for assistance. Frequent visual monitoring done. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 05/20/2025 at 6:29 PM by RN-S reflected Around 3:40 PM this nurse was aware by CNA that the pt is in the floor. Upon entering the room Resident found on the floor in the bathroom on side lying position, wheelchair is locked next to her. Assisted her back to wheelchair with the help of two person. Vital sign WNL. On assessment noticed small skin tear on It elbow with small amount of blood, dressing done. Notified wound care nurse. alert and orient with her baseline. Vitals WNL. Resident states she fell when transferring from commode to wheelchair herself. Complained of L leg pain, Tylenol 650 mg P O given, somewhat effective. NP, DON/ADON notified. RP made aware. Received new order to stat X-ray L Hip from NP. updated on portal. Neuros on progress and within normal limits. Bed in low position. fall precaution maintained. will cont. to monitor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:12 PM by RN-S reflected that X-ray of hip shows left femoral neck fracture. MD made aware. Called 911 and sent to [hospital]around 10 PM. Record review of Resident #1's nursing progress note dated 05/20/2025 at 9:43 PM by LVN-M reflected Spoke with [family member] directly about situation he states that he is in route to [hospital name] now and okay with mother being sent in ambulance. Record review of Resident #1's nursing progress note dated 06/08/2025 by LVN-A reflected Resident came back from the hospital on a non-emergency transportation on a stretcher and was transferred from stretcher to bed Resident had a fall in the facility and sustained a left hip fracture. Surgery was performed and has stitches on the left hip. Dressing is intact and surgical incision is showing visible signs of any infection or drainage. Resident is admitted on services [Hospice] visited the facility. [Hospice] is do present the DNR paper. Hospice has ordered to continue with the discharge orders. Resident is on day 1/3 of follow up for new medication (Tramadol) 50 mg every 4 hours for pain. Clarification is needed from hospice for delivery of Tramadol since order came from them. Hospice has also ordered Comfort Kit. Dietary is notified of the resident coming back. No complains of pain is voiced by resident. Oral fluids and call light is in easy reach. no paper. Hospice has ordered to continue with the discharge orders. Record review of Resident #1's nursing progress note dated 06/09/2025 at 1:13 PM by ADON reflected Follow up monitoring Day 1 of 3 of Re-admit with DX: L hip FX SX (symptoms) repair. AAOx1-2 (refers to the level of alertness and orientation, specifically indicating that a person is aware of who they are and where they are but may not know the current date and time (A&Ox1) or also what happened to them (A&Ox2). Spanish speaking. Under [hospice name]. Respiratory even and unlabored. No sob noted. No cough congestion noted. L hip surgical incision dressing CDI. Denies pain or any other discomfort at this time, Abdomen soft and non-distended bsx4. appetite fair. [Family member] present at bedside. Incontinent to B&B. Wound on Coccyx. (The small, triangular bone at the very bottom of the spine.) Wound care in progress. Turned and repositioned at regular intervals. call light and bedside table within reach. Bed in lowest position. Fall precautions implemented through the shift. call light within reach. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 06/11/2025 at 7:36 AM by the ADON reflected IDT review regarding skin tear to right elbow, obtained during assisted dressing with hospice aide, resident noted with thin/fragile skin resulting in increased risk of injury, site appears with steri strips intact no s/s infection or pain present, Geri sleeves applied for safety. (continued on next page)

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	676127	A. Building B. Wing	06/26/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of progress note dated 06/11/2025 10:41 AM by LVN-C reflected Follow up monitoring Day 3 of 3 of Re-admit with DX: L hip FX SX repair. AAOx1-2. Resting in bed with HOB elevated to facilitate easy breathing. Spanish speaking. Under [hospice name]. Resp even and unlabored. No sob noted. No cough congestion noted. L hip surgical incision dressing CDI. Medicated with PRN Tramadol. remains effective. Abdomen soft and non-distended bsx4 (Bowel sounds x 4 quadrants refers to the process of listening to the digestive sounds in all four quadrants of the abdomen) appetite remains poor. D1/3 of new orders of vitamin C, Zinc, House protein, 2.0 supplement, mm with min. Incontinent to B&B. Wound on Coccyx. LLE TTWB r/t DTI. Steri-Strips intact on R elbow. wound care in progress. Off loaded bilateral (in a medical context refers to the process of reducing or removing pressure from the heels on both the right and left sides of the body.) heels when in bed. Turned and repositioned at regular intervals. Ortho appt in am. call light and bedside table within reach. Bed in lowest position. Fall precautions implemented through the shift. call light within reach. will cont. to follow POC. Record review of Resident #1's nursing progress note dated 06/11/2025 at 12:40 PM by the ADON reflected left hip f/u X-ray results received and sent to NP for review NNOs (Neuronal nitric oxide syntheses (NNOS) is an enzyme that produces nitric oxide (NO), a potentially harmful molecule implicated in fetal brain injury under .) obtained, disk received for f/u Ortho appt. Record review of Resident #1's nursing progress notes dated 06/11/2025 at 10:49 AM by the ADON reflected Notified by [family member] of Ortho f/u appt on 6/12/20, f/u X-ray to left hip scheduled for STAT today with CD for appt. tomorrow. Record review of Resident #1's nursing progress notes dated 06/12/2025 at 1:52 PM by the ADON reflected Returned from Ortho appt, staples DC' D steri strips in place, LOTA, TX orders updated. Record review of Resident #1's nursing progress notes dated 06/12/2025 05:11 AM by the ADON reflected (L) hip FX sx repair; surgical dressings on L leg kept CDI; resident slept during shift with respirations even and unlabored. Day 2/3 F/U 2.0 suppository 90 cc TID, house protein 30 cc PO BID, Vit C, Zinc, and MVM with min and skin tear with steri strips. LLE TTWB r/t DTI to (L) heel; no complaints from resident at this time. Bed in low position with call light attached. Record review of Resident #1's nursing progress notes 06/23/2025 at 3:49 AM by LVN-C reflected resident with Steri-Strips to L Hip. LLE TTWB R/T DTI to L heel. Offload bilateral heels while in bed (in a medical context refers to the process of reducing or removing pressure from the heels on both the right and left sides of the body.). No c/o pain. Call-light within reach. Record review of Resident #1's nursing progress notes 06/23/2025 at 10:22 PM by LVN-C reflected Resident with Steri-Strips to L Hip. LLE TTWB R/T DTI to L heel. Offload bilateral heels while in bed. No c/o pain. Call-light within reach. Record review of Resident #1 event note dated 06/10/25 at 12:23 PM by the ADON reflected IDT review: witnessed: no injuries: skin tear right elbow sent to ER: not indicated all parties aware: yes intervention: Geri sleeves BUE HX of similar events: Physician notified at 10:30 AM, Resident Representative notified at 12:27 PM, Care plan revised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 10:15 AM with the ADMIN, stated the incident occurred on 05/20/2025 and he did not investigate or submit a self-report for the incident. The ADMIN said he did not have the staff write a statement detailing the incident, however, he would check for a written statement. The ADMIN was asked to provide names of the staff involved, daily schedules of the staff with their full name documented for the day of the incident, and an employee roster. The ADMIN stated that there were two aides involved and he would provide their names. The ADMIN stated the CNA-F placed resident on the toilet, then told CNA-J that Resident #1 was left on the toilet and follow up with checks on the resident. The ADMIN stated that Resident #1 was left on the toilet for 5 minutes. The ADMIN stated they requested privacy and waived her hand for CNA-F to leave the bathroom. The ADMIN said after 5 minutes had passed CNA-F returned to Resident #1's room to check on her and heard her fall. The ADMIN said CNA-F called out for CNA-J to come and help with the resident to transfer her off the bathroom floor. The ADMIN stated that RN-S assessed Resident #1 and notified the MD, ADMIN, ADON, RNC, and POA. The MD ordered X-rays immediately. The ADMIN stated once the X-ray results were reviewed by the MD, EMS was called, and she was transported to the hospital emergency room. The ADMIN said Resident #1 returned from the hospital with hospice services and assessments for therapy. The ADMIN stated that the facility did not have a DON currently and the RNC and ADON were in charge of the nursing department. The ADMIN stated that the RNC was not at the facility at this time. He stated that the resident requested privacy from the CNA -F and it was granted. During an interview on 06/24/2025 at 10:25 AM the ADON stated that the hospital records located in the Resident #1's clinical file to review. The ADON stated that the POA was notified and later visited Resident #1. The ADON stated that Resident #1 received immediate care after her fall by RN-S and CNA-F. She said Resident #1 had a skin tear to her left elbow. She said RN-S assessed Resident #1, notified the on-call nurse, RNC, ADON, and POA. ADON said the MD ordered immediate X-rays for the resident. The ADON said once the X-ray result was reviewed by the MD, Resident #1 was sent out via emergency transport to the hospital, where it was later confirmed she had a fractured hip. The ADON said hospice services were ordered upon her return to the facility on [DATE]. The ADON stated Resident #1 had a previous fall incident and almost fell, but a CNA (name unknown), was present and prevented the fall. The ADON stated that Resident #1 was assessed, and the facility recorded the incident and followed the fall protocol. The ADON said Resident #1 was assessed for falls, the care plan was updated, and she was placed on 72-hour post fall observation and monitoring as a precaution on 04/15/2025. On 06/24/2025 at 10:30 AM, the ADON provided the names of the staff involved without contact information. During and observation and interview of on 06/24/2025 at 11:13 AM Resident #1, revealed she was Spanish speaking with some English. Resident #1 said she did not know how she fell and did not remember. She stated that she did not know how to use the call light. Resident #1 was lying in bed; a fall mat was next to bed and the call light was in reach. Upon further observation Resident #1's communication board/picture board was not in the room. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 11:15 AM with the FM, she stated that Resident #1 had dementia and could not use the call light. The FM stated that Resident #1 was unable to use the call light, due to her dementia. FM said Resident #1 required total assistance from staff. The FM said Resident #1 had a communication/picture board for communication. FM said she searched for Resident #1's communication picture board, and it was not in her room. The FM said upon returning to the facility she and the POA installed a video camera to supervise and communicate with Resident #1. The FM said she and the POA had not observed the staff utilizing the picture board to communicate with Resident #1 since returning to the facility on [DATE]. The FM said Resident #1 could respond to some questions, but the picture board was implemented by the facility to assist with communicating her needs to the staff. FM said she later found out by the POA that the communication board sent home at the time of discharge to the hospital. The FM said Resident #1 had declined significantly, she is bed bound most of the day, and receives hospice care due to bleeding on the brain from the fall 05/20/2025. During a phone interview on 06/24/2025 at 11:51 AM with the POA, the POA stated that he received a call from the facility that Resident #1 had fell in the bathroom and the MD ordered X rays. The POA said he arrived at the facility on 05/20/2025 an hour after the call (exact time unknown) and observed 1 shoe of Resident #1 and blood still on the bathroom floor from Resident #1's fall. The POA said Resident #1 could not use the call light, despite ongoing education by the staff, FM, and POA. The POA said Resident #1 was a fall risk from a previous fall in April 2025. The POA said Resident #1 should have never been left on the toilet alone. The POA said the staff were not using the picture board to communicate with Resident #1. The POA said he believes Resident #1 was left alone on the toilet for more than 5 minutes, causing the fall and injuries on 05/20/2025. The POA said after the fall he installed a camera and communicates with Resident #1 via camera. The POA said the staff assigned was aware of Resident #1's needs to be supervised due to falls, yet she left Resident #1 on the toilet unsupervised. The POA said he has observed staff taking 25 minutes to take Resident #1 to the bathroom, then leave the resident alone. POA said Resident #1 was not able to ask for privacy from the staff due to her cognitive decline. The POA said he does not believe that the staff were near the bathroom when Resident #1 fell. POA said he does not know the name of the staff that was working. POA said upon arrival to the hospital he was told that Resident #1 had a femur and hip fracture on the left side, skin tears to the left elbow, bleeding on the brain, and was being monitored. POA said the hospital conducted surgery to repair Resident #1's hip. POA said Resident #1's mental acuteness (awareness) had diminished since the fall. POA said Resident #1 was admitted to the facility to receive care, and now that she fell and was hospitalized , she requires total staff assistance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 06/24/2025 at 2:10 PM with CNA-F, revealed as she was walking past Resident #1's room she observed the resident trying to get out of bed independently. She went to assist the resident, and she could not understand her response and what she was saying, because the resident was speaking in Spanish. CNA-F said she called CNA-J (a Spanish speaking employee) to communicate Resident #1's needs. CNA-J told CNA-F that Resident #1 wanted to put her pajamas on for bed. CNA-F said once Resident #1 was dressed, she returned the resident to sit in her wheelchair, and she attempted to get out of the chair. CNA-F said she assumed Resident #1 wanted to go to the bathroom, so she assisted. CNA-F said Resident #1 was transferred to the toilet in her bathroom. CNA-F said she remained in the bathroom initially, until Resident #1 gestured with her hand to leave the restroom. CNA-F said she notified CNA-J caring for a patient in another room, that Resident #1 was on the toilet, and to check on her while she resumed care of another resident. CNA-F said about 2 to 3 minutes later as she was walking down the hall, she remembered Resident #1 was on the toilet. CNA-F said as she entered the room, she heard Resident #1 fall. She immediately called RN-S for help. CNA-F said the fall was unwitnessed, and did not think Resident #1 hit her head. CNA-F said Resident #1 was bleeding from her left elbow. CNA- F said Resident #1 was in pain. CNA-F said she did not observe any other injuries, lumps, or bruising to the head. She was in pain. CNA-F said Resident #1 was talking and answering the nurse's questions and responding. CNA-F said she was not familiar with Resident #1's clinical needs, nor could she speak Spanish. CNF-A said she did not know that Resident #1 was a fall risk and could not be left alone in the bathroom. She said this was a one-time incident and she gave the resident privacy. During an interview on 06/24/2025 at 2:15 PM with RN-S, revealed she had been working at the facility for 9 months. RN S stated that she was familiar with Resident #1's care and knew that she was a fall risk. RN-S said she worked the day of Resident #1's fall, 05/20/2025. RN-S said CNA-F called for her assistance with a resident that fell, so she immediately responded to the room. RN-S said Resident #1 was found lying on the floor in the bathroom on her left side with a skin tear to the left elbow. RN-S said the resident was alert and communicating with her and she did not lose consciousness. RN-S said the resident understood English and Spanish. RN-S and CNA-F assisted Resident #1 to the wheelchair. RN-S said she called the MD and the on-call nurse to report the incident. RN-S stated that the MD ordered immediate Xray's. RN-S notified the POA, and he wanted to delay sending Resident #1 to the hospital, and she explained that the facility policy was to provide immediate care and transport to the hospital for further assessment of the injuries. RN-S said she gave her Tylenol for pain at 6:25 PM. RN-S said the portable X-ray technician arrived 9:00 PM. RN-S said once the X-rays were reviewed by the MD resident was sent to the hospital. RN-S said Resident #1's base line prior to fall included providing assistance to stand, eat, and all care. RN-S denied knowledge of Resident #1 having a picture board to communicate with staff. RN-S said Resident #1's cognition was the same after the fall, she had not observed any changes. RN-S said Resident #1 used non-verbal signals to communicate and she could answer yes and no to most questions. She said she was aware that Resident #1 was a fall risk. RN-S said Resident #1 should not be left alone, due to a history of falls and decline in cognition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/24/2025 at 2:38 PM with CNA-J revealed she had placed Resident 1# in bed and proceeded to assist another resident with care. CNA-J said CNA-F did not tell her that the resident was in the bathroom on the toilet and to monitor. CNA-J stated that Resident #1 requires assistance from the staff with transfers and she could not self-transfer or ambulate. CNA-J said she would not have left Resident #1 unsupervised or alone in the bathroom, due to her diagnosis of Dementia and increased confusion. CNA-J said Resident #1 communicate in Spanish and say yes and no. She does not know how long CNA-F left Resident #1 on the toilet. CNA-J was told about the incident later that evening. CNA-J said CNA-F and the nurse responded to the fall. CNA-J said residents should never be left alone on the toilet, because a frequent movement could result in a fall. During an interview on 06/24/2025 at 5:00 PM with the ADMIN, revealed that that CNA-F notified CNA J to monitor Resident #1 on the toilet. The ADMIN insisted that the resident was being monitored by CNA-J and had been left for 2 to 3 minutes. The ADMIN stated that Resident #1 was a fall risk at her bedside, not in the bathroom, and she had a right to request privacy. The ADMIN said any resident could fall from the toilet and have injuries. The ADMIN returned at 5:34 PM and stated that he was not sure if he had statements, and he had to investigate further because CNA-J's and CNA-F's stories were not adding up. The surveyor stated that in the interview with CNA-F, she stated that the nurse was immediately notified not CNA-J. The ADMIN stated that he may have confused the staff statements with notification of help when Resident #1 fell. During another interview with the ADON on 06/24/2025 at 6:09 PM with the ADON she stated that the resident could use the call light prior to the fall. The surveyor explained that the resident stated she did not know how to use the call light this morning during an interview. The ADON stated that she could before the fall now she couldn't. The ADON was asked about the communication board that was care planned to communicate with the staff. She said she did not know where it was. The surveyor told her the FM stated that the board was sent home upon her discharge to hospital on 5/20/25. She said if they picked the communication board up and did not return, there was nothing she could do. She stated the resident could not communicate. The surveyor asked if pictures of tasks were documented on the board, and she said yes. The surveyor asked if the communication board was care planned currently, she said yes. During an interview with the ADMIN on 06/25/2025 at 12:10 PM he stated that he did not submit a self-report to HHS about the incident, however, he completed the investigation on 05/26/25. Record review of CNA-F written statement dated 5/20/25 (provided by the ADMIN on 06/24/2025 at 5:50 PM ADMIN) reflected CNA-F did not seek further assistance from anyone, and while she was attending to another task, Resident #1 may have been unsupervised longer than 1 to 3 minutes. During a second interview on 06/26/2025 at 11:02 AM the PO, stated that Resident #1 was not able to verbalize how she fell after being asked several times by him, the FM, and the staff. The POA denied hearing Resident #1 say what happened on 05/20/2025, and he never translated or communicated a statement from Resident #1 to the ADMIN or staff at the facility about the fall. During a second interview with the FM on 06/30/2025 at 11:40 AM, she stated that Resident #1 was unable to communicate what happened with the fall, due to her dementia, and injuries after the fall. She stated that she had asked Resident #1 on multiple occasions with the POA, and she couldn't recall what occurred. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility investigation completed by the ADMIN on 05/26/2025 revealed investigation report Subject: Incident Involving Resident #1 - Bathroom Fall Resulting in Hip Fracture Resident Information: Name: [Resident # 1] Date of Incident: May 20, 2025, Date Reported: May 20, 2025, Cognitive Status: BIM's Score - 8 Primary Language: Spanish and speaks some English. Incident Summary: On May 20, 2025, I, [ADMIN] LNFA, was notified of an X-ray result confirming that Resident # 1 sustained a fractured hip following a fall in the bathroom. Upon notification, I immediately contacted [name] ADON, and [name] ADON-T, to begin reviewing the details of the incident. Narrative of Events: According to documentation and staff interviews: o [CNA-F] escorted [Resident #1] to the restroom. o the resident requested privacy by verbally dismissing CNA-[CNA-F] and pointing to the call light cord, indicating she understood how to call for assistance. o [Resident #1] has a BIMS of 8, suggesting moderate cognitive impairment, but she has consistently demonstrated the ability to use the call light[TRUNCATED]