STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676168	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092 Based on observation, interview and record review, the facility failed to immediately inform the resident's physician and notify, consistent with his or her authority, notify a resident's representative when there was an accident involving the resident and/or when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 5 residents (Resident #1) reviewed for notification of changes in that: The facility failed to promptly notify Resident #1's physician and responsible party when Resident #1 exhibited cries of pain on 6/8/24 and verbally stated ow, my leg while crying in pain again on 6/9/24 after falling and suffering from a fracture of the right femoral/femur neck on the right hip on 6/07/24. She did not receive an X-ray until 06/10/2024 when Resident #1's responsible party sent a video recording of her crying in pain to the hospice provider. She was not sent out to be admitted to the hospital for treatment for over 65 hours although she was crying out in pain until 06/10/2024 at approximately 3:29 PM. An immediate Jeopardy (IJ) situation was identified on 06/13/2024 at 12:59 PM. While the IJ was removed on 06/14/2024 at 12:00 PM, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm that is not immediate jeopardy because all staff had to be trained on who to notify if they were to discover a resident crying out in pain and a change in behavior. This deficient practice could place residents at risk of not having their RP or physician informed when there is a change in condition resulting in a delay in medical intervention and decline in health. Findings included: (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's face sheet dated 06/10/2024 reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses of unspecified dementia, unspecified severity, without behavioral/psychotic/mood/anxiety. Other prior diagnosis consist of person history of transient ischemic attack (a stroke that lasts only a few minutes), and cerebral infarction without residual deficit, dysphagia (difficulty swallowing), unspecified gastritis (Inflammation of the lining of the stomach), unspecified, without bleeding, gastro-esophageal reflux disease without esophagitis (stomach acid repeatedly flows back up into the tube connecting the mouth and stomach), nontraumatic intracerebral hemorrhage (a common subtype of stroke with a poor prognosis), unspecified, hyperlipidemia (an elevated level of lipids), unspecified hypertensive chronic kidney disease with state 1 through stage 4 chronic kidney disease (Stage 4 CKD means you have severe loss of kidney function), or unspecified systolic heart failure, age related physical debility, pain, unspecified, major depressive disorder, single episode, unspecified, constipation, unspecified, heart failure, unspecified, chronic kidney disease, unspecified, essential hypertension, cerebral infarction (stroke), unspecified, aphasia following cerebral infarction, expressive language disorder (lower than normal ability in vocabulary), dysuria (sensation of pain and/or burning, stinging, or itching of the urethra or urethral meatus associated with urination), weakness, localized edema (when tiny blood vessels in the body, also known as capillaries, leak fluid), chronic atrial fibrillation (heart arrhythmia that causes the top chambers of your heart, the atria, to quiver and beat irregularly), unspecified, other chronic pain, shortness of breath, chronic kidney disease, stage 3 unspecified, unspecified sequelae of cerebral infarction, unspecified macular degeneration (a disease that affects a person's central vision), anemia, unspecified, cardiomegaly (umbrella designation for various conditions leading to enlargement of the heart), unspecified abnormalities of gait and mobility, contact with and suspected exposure to covid-19. Family Member A was listed as the power of attorney. Record review of Resident #1's Annual MDS Assessment, dated 04/3/2024, reflected Resident #1 had a BIMS score of 3. Resident #1 was assessed to require assistance with ADL's including the following: transfers, eating, personal hygiene, showers, and dressing. Resident is on hospice and has an active PRN order of Morphine for pain management. Record review of Resident #1's Comprehensive Care Plan revised on 06/10/2024 reflected Resident #1 had sustained a right hip fracture. Intervention: For no apparent acute injury, determine and address causative factors of the fall. Monitory/document/report PRN x 72 h to MD for s/sx: Pain, bruises, Change in mental status, New onset: confusion, sleepiness, inability to maintain posture, agitation. Neuro checks. Provide activities that promote exercise and strength building where possible. PT consult for strength and mobility. Pharmacy consult to evaluate medications. The resident did not have a history of falls so there were no preventions in place. Record review of Resident #1's Incident Report completed by RN N, dated on 06/07/24, reflected Resident #1 was found by RN N. RN N stated in the incident report Heard someone yelling down 300 hall. Went immediately down to check to see who it was. Found resident lying on her back beside the bed. Had rolled out of the bed on the side by the window. Bed had been in the lowest position. Call light had been within reach, but resident really doesn't use it due to dementia. She was awake and alert. When first walking into the room she was noted to be moving all extremities on her own and on further assessment would move them on command or with checking of ROM. No skin tears or bruises noted at this time upon assessment. Neuro checks initiated. WNL. Notified DON, Dr, Hospice, and responsible party. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's electronic medical records date 6/10/2024 reflected Resident #1 did have a pain assessment note that was entered by LVN R. It reflected, Pain assessment q shift using PAINAD/ Dementia Scale 0-10 Pain Intensity Goal 0-2 every shift. Record review of Resident #1's Hospice Nurses revealed a hospice note dated, 06/09/2024 revealed, Facility staff called stating that pt has a decline in condition stating that 02 sat had dropped to 89 and pt was given oxygen nc 2l and 02 sat increased to 94. Pt also did not eat breakfast upon my arrival to facility, facility staff said pts responsible party just left the facility from visiting with pt. pt is lying in bed in a supine position (lying horizontally with the face and torso facing up). Pt has oxygen nc running at 2l with 02sat of 94. Vs wnl but facility staff report was in pain earlier and was given morphine for pain management as ordered. Pt was sleeping when I arrived and did not wakeup during assessment. Facility staff reported that pt has been having difficulty swallowing solids and liquids, so she did not take her medications today nor eat or drink. Pt is in deep sleep all through assessment. Teaching done with facility staff to hold on liquids and food if pt is unable to swallow for aspiration precaution (inhaling some kind of foreign object or substance into your airway). Pt is not in pain at time of evaluation. Facility staff advised to contact hospice with any concerns or change in condition. Responsible party was called for update and no answer. Record review of a hospice note created by HSP T dated, 06/10/2024 reflected Resident #1 is a [AGE] year-old female. admitted to hospice with diagnosis Senile degeneration of brain. Seen for skilled nurse visit LVN. Patient lying in bed for assessment. Patient lethargic this am. Unable to verbalize needs. Skin warm and moist to touch. 02 via nasal cannula at 3 liters. Noted nonverbal signs of pain with assessment and care. [NAME] [sic] motions with hands. Facial grimace and agitation in the am. Nebulizer given. Record review of Resident #1's Medication Record dated 06/01/2024 to 06/10/2024, reflected Resident #1 was not given morphine for pain on Saturday, Sunday, Monday, Tuesday, Wednesday, and Thursday leading up to the fall that she had on Friday. However, she did receive morphine on Friday before the fall at 7:44 AM pain scale 7 and again at 10:22 PM pain scale 3, Saturday at 7:37 AM pain scale 7, Sunday at 3:39 AM pain scale 5 and 3:08 PM pain scale 7 and Monday at 7:44 AM pain scale 7 and 12:12 PM pain scale 9. Each of the times Resident #1 received Morphine it was documented as being Effective. The resident does have an active PRN order for Morphine. Record review of Resident #1's Hospital Records dated 06/10/2024 reflected a Right Femoral Neck Fracture, Acute Kidney Injury, Altered Mental Status, Hypernatremia, Hypoxic Respiratory Failure (don't have enough oxygen in your blood), and Sepsis (serious condition in which the body responds improperly to an infection). The hospital record reflect that the resident was brought by EMS from the nursing home where she was found to be altered from baseline with decreased responsiveness and incomprehensible speech, also having fallen from a bed to floor with a right hip deformity and a pain film that showed a hip fracture at the nursing home. Record review of LVN A's signed facility statement dated 06/13/2024 reflected that on Saturday 6/8/2024 LVN A was notified of Resident #1's pain by CNA S. LVN A performed an assessment which showed there was no indication of a fracture. LVN A administered pain medication. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of LVN A's signed facility statement dated 06/13/2024 reflected that on Sunday 06/09/2024 LVN A was notified of Resident #1's leg pain by CNA B. LVN A performed an assessment which showed that she was aligned, no bruising, no swelling, her skin and right hip appeared normal in temperature. LVN A administered pain medication. Record review of LVN A's signed facility statement dated 06/13/2024 reflected that on Sunday 06/09/2024 the Hospice Nurse assessed Resident #1 and found no concerns or brought forth that there was a right hip fracture. Record review of RN O's signed facility statement dated 06/13/2024 reflected that on Sunday 06/09/2024 RN O was making rounds on the residents and observed Resident #1 lying in bed with her eyes closed. She stated that Resident #1 was calm, not tearful or frowning. She performed a head-to-toe skin assessment and did not find any visual indications of swelling, bruising, or changes in skin appearance or temperature during her assessment. She stated that Resident #1 made no verbal complaints or facial indicators that she was experiencing pain during her assessment. Her body was aligned. She then stated that she received a call from the Hospice Clinical Director stating that an x-ray was ordered on 06/10/2024 which revealed findings of the bones being osteoporotic. It also revealed an acute right intertrochanteric femoral neck fracture. Record review of a recorded video dated Sunday 06/09/2024 revealed CNA C performing a cleaning and changing on Resident #1 while Resident #1 was crying out in pain and verbally saying ow, my leg. In an interview on 06/11/2024 at 9:00 AM, the DON stated Resident #1 had a fall with a right hip fracture on Friday 06/07/24. She stated that her bed was in the lowest place and that there was no bruising, redness, or swelling. She stated that it was discovered that she had a trochaic femoral neck fracture (hip fracture). She stated that this was confirmed by an x-ray that was taken on Monday 06/10/2024. She stated that Resident #1 has osteoporosis and was on hospice. She stated that her bed was always in the lowest position. Her bed was in the lowest position for her safety. Her physician decided that as an intervention. She stated that Resident #1 was not paralyzed. She doesn't have a ton of mobility. She stated that RN N was working on the night of the fall and that she assisted with getting Resident #1 off the floor. She stated that RN N asked what happened, ad Resident #1 stated that she was looking for her family member. She was not on any restraints. The facility is a restraint free facility. There are bed rails, but they are not a restraint. They are a turn assist only. She stated that Resident #1 does have a behavior of crying out in pain. She has a history of intermittent lower back pain. She will cry out during repositioning, but she will calm back down. She does have thin skin on her arms and legs. If it's easily bumped, it will bruise. She does not have any blood disorders. She stated that the Physician, Hospice, and Responsible Party were notified of the fall. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/11/2024 at 10:10 AM, LVN R stated that she worked Monday-Wednesday 6AM-6PM. She stated that on 6/11/24 Resident #1 was still sleeping at 6 AM. She stated that she went in her room and tried to wake her up, but she looked different. She couldn't respond to what she was being asked. Her temperature was elevated. She stated that she gave her morphine for pain because she was told that she had fallen and that she did not see any bruising on her when she changed her. She stated that she notified hospice of a change in condition at around 8 AM. Hospice returned the call and then the nurse showed up before lunch. There were no injuries to her head that she know of. She stated that she checked her and didn't see any more bruising than normal. She stated that Resident #1 does have bruising or skin tears on her arms. She stated that Resident # 1 does cry out a lot in pain because her stomach and back hurts. She stated that the resident has cancer in the abdomen area, and that is why she was on hospice and had pain. She stated that every time she changed her, she screamed. She stated that it was a little bit more than normal. She stated that she does not know of any blood disorders. She does bruise very easily. She is on a fluid restriction and has very thin skin. In an interview on 06/11/2024 at 11:50 AM, RN N stated that she was working on the night Resident #1 fell , 6/07/24. She stated that she was at the desk charting and heard somebody yelling from down the hall, so she went to check the rooms. She stated that she immediately went down the hall once she heard the screaming coming from Resident #1's room. She stated that it occurred around midnight. She stated that she did not know where the CNA was at. She stated that Resident #1 had fallen off the side of the bed by the window. It was the right side. The bed was in the lowest position which was unusual for her. She stated that Resident #1 was moving her arms and legs when she got into the room and stated that it seemed like she was trying to get back into bed. She stated that Resident #1 was squirming but that she was able to check for her range of motion. She checked her vitals and neural checks. It was all fine. She stated that she contacted the doctor, hospice, DON, family member, and just kind of went from there. She stated that Resident #1 had turned herself around; her head was at the foot of the bed. Her arms were reaching towards the bed. Her legs were moving. She was trying to get back onto the bed not realizing that she couldn't. He right side was weakened and that she assumed that she pushed with her stronger side, her left side until she managed to get turned around. She stated that she had never fallen before. She said that she was looking for her family member. She stated that she kept asking Resident #1 different questions, but she wasn't really responding to them. She just kept saying that she was looking for her family member. There was not a mat on the floor that night. She stated that she put in an order to get mats on the floor. She stated that she could not get the door open to where she thought the mats were. She stated that when she assessed her, she did not see any skins tear or bumps. In an interview on 06/11/2024 at 12:40 PM, LVN A stated he was informed on 6/8/2024 that Resident #1 had fallen on 6/7/2024 overnight. He stated that RN N told him that she had found her lying on the ground. He stated that her hospice doesn't come on Saturday. He stated that he had been giving her morphine over the weekend because she was in pain. He stated that he gave her morphine on Saturday 06/08/2024 and Sunday 06/09/2024 just to make sure she was comfortable. He stated that it is common to give her morphine because she is on hospice and has a history of pain. She was in bed, and nobody reported to him that she was in severe pain. He stated that her family came to visit her. Her responsible party stayed in the room with her while they did a breathing treatment for her. Her oxygen was 90. He stated that they raised her head up and she was unable to swallow. He stated she bruised easily and that he did not get a report on her being in pain during the routine changes. He stated that nobody told him about her crying out in pain. He stated that the morphine was effective at treating her pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/11/2024 at 3:00 PM, Resident #1's Family Member B stated that she had recorded a video while she was in Resident #1's room of the nurses changing her while she was crying out in pain. She stated that her leg was in pain and that she informed Resident #1's Responsible Party that something was wrong. She stated that she frequently visited Resident #1 and was aware of the fall that had recently occurred. She was under the impression that there were no injuries so she was shocked to see her screaming in pain and verbally saying ow, my leg when she was at the facility. She stated that she did not know the staff members by name but that it was obvious something was wrong and that they had to have known about it. In an interview on 06/12/2024 at 12:40 PM, the Physician stated he was not notified of any crying of pain or incident except when the facility contacted him about Resident #1's fall on 06/07/24. He stated he was not notified of Resident #1 being found crying out in pain or saying ow, my leg. He stated that had he had known that then it would have indicated that Resident #1 be further evaluated and received an x-ray sooner which would have revealed the fracture sooner. The Physician stated the Administrator, DON, ADON or a nurse should always contact him if there was a fall, pain, or any change of condition with a resident. The Physician stated Resident #1 could have fractured her hip falling from any height because of the osteoporosis diagnosis. He stated she did have brittle bones and it would be difficult for him to determine if Resident #1 may have broken a bone falling from a low bed height or a normal bed height. He stated that Resident #1 required maximum activities of daily living and was on hospice with chronic pain. He stated that she had pain issues in the past and had behavior issues in the past. He stated it would be hard to know without there being a visual indicator that something was wrong because the resident could be having a normal behavior. However, because Resident #1 verbally said ow, my leg there should have been attention brought to the leg. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/12/2024 at 1:20 PM, HSP Q stated that he was the Clinical Director of the hospice company. He stated that Resident #1 had a hip fracture and that her Responsible Party was upset. He stated that the hospice company could only do a mobile x-ray. It's not as good as the one they can do in the hospital. He stated that the only notes that the hospice agency received from the facility was when the facility called the answering service about the fall that occurred on Friday 06/07/2024. He stated that the facility had sent out a brief message saying that the patient had fallen or something like that. He stated that it was his understanding that there was no injury. He said that he didn't even know about the pain or anything that Resident #1 was having until Sunday 06/09/2024. He found out about the leg pain because the Responsible Party sent him the video of Resident #1 crying out in pain. He stated that is when the hospice nurse went out to check on Resident #1. Another nurse went back on Monday 06/10/2024 to check on her again and that's the day that she was sent to the hospital. He stated that he chose to do the x-ray because there must be something more wrong with her if she was in pain. He stated that she had back pain for a while and that's normal for her to complain of that but not about her leg. He stated that some fractures are small enough that they don't show up until there has been some movement and stuff. He stated that the nurse that performed the assessment after the fall stated that the resident wasn't crying and that there was no indication of any fracture, so they put her back in bed. He stated that if Resident #1 started showing signs of changes or complaining about her leg hurting then the facility should have done something. He stated that the facility should have called the hospice company to tell them what was going on. He stated that she can communicate pain. Once the facility started noticing that there was pain, they should have or could have called the hospice company. He stated that he saw the video of Resident #1 crying out in pain on Monday 06/10/2024 and ordered the x-ray. He stated that the hospice nurse that performed the assessment on Sunday 06/09/2024 did not mention anything about Resident #1 being in pain at that time. He stated at the end of every on-call section, hospice will write a synopsis usually saying something like not eating much or something like that. There was no mention of pain. He stated that the LVN had administered pain medication and that could have masked her symptoms. He stated that Resident #1 has a history of chronic pain, and that morphine keeps her comfortable. When asked if the hospice nurse on Sunday should have discovered pain during the assessment from something like a test of Resident #1's range of motion he stated, You will certainly not want to be moving the leg around if you suspect a break. You should look to see if you could bend it without pain. But yeah, she could have done the assessment if she had any notion that there might have been an injury. He stated that the hospice agency was not aware of any injury at that time. He stated that the change in condition was initially because Resident #1 was not swallowing. It was not about pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/12/2024 at 1:50 PM, CNA C stated that she worked with Resident #1 on Friday 06/07/2024 before her fall occurred and again on Sunday 06/09/2024. She stated that when she arrived to work on Sunday morning, she noticed that Resident #1's bed was lowered which seemed off, that her leg was propped up with a pillow underneath it, and that Resident #1 seemed out of it. She stated that she went straight to LVN A and informed him that something was wrong. She stated that LVN A told her that Resident #1 had a fall. She stated that she changed Resident #1's gown and that's when Resident #1 began screaming saying my leg, my leg, my leg. She stated that Resident #1's leg wouldn't lay down straight. She stated that Resident #1 was having a change in condition from her previous shift that she had worked with her on Friday 2 days before. She stated that Resident #1 would not eat her food, she would just let it sit inside her mouth. She said that Resident #1 normally ate her food without problem and that she normally ate all of it. She stated that she could tell something was different immediately when she entered the room. She stated that she had never heard Resident #1 complain about leg pain before. She stated that the family was in the room with her when she did another changing and that they were very upset. She stated that as soon as she tried to do another changing Resident #1 immediately started complaining about her leg again saying ow, my leg. The family started asking what had happened to her, so she told them that she had fallen over the weekend and that she didn't know what was going on other than that. She stated that she did not know if LVN A knew about Resident #1's leg pain before her shift started but she believed that he did. She told him during her shift. She stated that the Weekend Supervisor had called hospice so that they could perform an assessment. She stated that when she had worked on Friday everything was normal. She stated that on Friday her oxygen was normal, and that Resident #1 had fed herself 3 meals. She knew something was wrong. She stated that Resident #1 wasn't even going to the bathroom like she normally would. She stated that the first time she heard Resident #1 say something verbally about her leg was at around 7:30 AM and that's when she told LVN A. She stated that the leg didn't look right and that it was turned. She stated someone had to have known because the leg was propped up on a pillow. She stated that her leg looked bruise with purple dots and that she has never seen that on her leg before. In an interview on 06/12/2024 at 2:03 PM, RN O stated that she was the Weekend Supervisor that worked with Resident #1 and LVN A on the weekend of 6/8/24-6/9/24. She stated that she spoke to the Responsible Party and that he was upset. She understood that he was upset and stated that anyone would be upset if their family member was in the same situation as Resident #1. She stated that the Responsible Party had told her that Resident #1 did not recognize him, so she called the hospice nurse who came and assessed her. She stated that Resident #1 was not the most verbal resident and that she was not in pain. She stated that she did not hear anything about her having leg pain. In an interview on 06/12/2024 at 2:30 PM, the Administrator stated he was not notified of Resident #1 being found crying with leg pain. He stated his expectations was for a nurse to assess a resident anytime a resident was found to be in pain or showing any signs of a change of condition. The Administrator stated that there were no nurses notes about Resident #1 complaining of leg pain on the assessments or incident /accident reports. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on 06/12/2024 at 3:40 PM, when the Investigator asked if it would have changed the outcome if she had known earlier about the resident crying out in pain on Saturday and Sunday instead of waiting until Monday, she stated that I can't say that it would have changed the outcome or if getting an x-ray earlier would have changed the outcome. She stated that it would have brought a concern to her that Resident #1 was in pain and crying. If so, then the nurse staff would call hospice or call the physician again. She stated that the staff did not witness the resident crying out in pain saying ow, my leg on Saturday and Sunday. She stated that the staff had not had an indication that she was crying in pain. She stated that if the staff had heard Resident #1 crying out in pain, then they should have called hospice and told the physician about her complaining of pain. She stated that it would be the responsibility of the LVN or RN to notify. In an interview with LVN A on 06/12/2024 at 3:48 PM, when the Investigator asked if he had known about Resident #1 crying out in pain on Saturday and Sunday, he stated that he did not know about her leg pain during his shift and that nobody ever told him. He stated that Resident #1 was in her bed all day and that he gave her pain medicine because she was on hospice. He stated that she has a PRN order for the Morphine for pain management. In an interview with CNA B on 06/12/2024 at 4:54 PM, she stated that she had worked with Resident #1 on Saturday 06/08/2024 and that she had worked with her for 3-5 years. She stated that on that morning Resident #1 was different. She stated that Resident #1 was screaming while she was being changed. That occurred after breakfast between 8:30-9AM. She stated that she was not able to understand her. She stated that she did not even know that she had fallen. She went to ask LVN A and he told her that she had a fall. She stated that she noticed that she was screaming whenever she was being changed. She did not eat much. She stated that she did not remember her complaining about her leg. She just knew that she was in pain. She never said ow, ow my leg hurts. She stated that she asked Resident #1 questions, but she didn't speak. She stated that she told LVN A about her being in pain and that he just told her that she had fallen. She was only screaming in pain whenever she was being changed. She stated that Resident #1 would scream if there was any movement. If she moved at all then she was screaming. That was totally different than her normal. She stated that she had changed her many times and she had never screamed like that. She wasn't talking at all. She stated that she had to also feed her because she wasn't eating on her own. She stated that she told LVN A and that she believed he gave her medicine for pain. Record review of Resident #1's electronic medical records 06/07/2024- 06/10/2024 reflected Resident #1 did not have any pain assessment note entries that stated she was crying out in pain or complaining about her leg being in pain on 06/8/2024 or 06/9/2024. She did have a pain assessment on 06/8/2024 but it was checked 0 for no pain, and 0 for no injury. It was also checked that she was given morphine. Record review of Facility Policy on Change in a Resident's Condition or Status: 1. The nurse will notify the residents attending physician or physician on call when there has been a(an): a. Accident or incident involving the resident; b. Discovery of injuries of an unknown source; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676168	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rambling Oaks Courtyard Extensive Care Community	112 Barnett Blvd Highland Village, TX 75077

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Adverse reaction to medication; d. Significant change in the resident's physical/emotional/mental condition; e. Need to alter the resident's medical treatment significantly; f. Refusal of treatment or medications two (2) or more consecutive times); g. Need to transfer the resident to a hospital/treatment center; h. Discharge without proper medical authority; and/or i. Specify instructions to notify the physician of changed in the residents condition. 2. A significant change of condition is a major decline or improvement in the residents status that; a. Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting'); b. Impacts more than one area of the residents health status; c. Requires interdisciplinary review and/or revision to the care plan; and d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 4. Unless otherwise instructed by the resident, a nurse will notify the residents representative when: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the residents physical, mental, or psychosocial status. c. There is a need to change the resident's room assignment. d. A decision has been made to discharge the resident from the facility; and/or e. It is necessary to transfer the resident to a hospital/treatment center. 5. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the residents medical/mental condition or status. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified on 06/13/2024 at 12:30 PM, that an Immediate Jeopardy had been identified due to the above failures and an IJ template was provided at 12:59 PM. The following POR was accepted on 06/14/2024 at 10:26 AM: Date 06/14/24 On 06/11/24 a facility investigation was initiated at the facility. 06/13/24 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an Immediate Jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure care was provided by qualified persons in accordance with professional standards of practice. Plan of Removal completion date is 06/13/24 with continuation of oncoming staff and follow-up. 1. Resident #1 is currently in the hospital. [TRUNCATED]