

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Tuscany Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2750 Miller Ranch Rd Pearland, TX 77584	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44241</p> <p>Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 4 residents.</p> <p>The facility failed to provide adequate supervision when CR#1, who was identified as a high fall risk, sustained a fall, and was discovered on the floor, nude, with a head injury, and in rigor mortis.</p> <p>This failure could place residents at risk for serious injury, serious harm, serious impairment or death (unwitnessed falls going unnoticed for extended time which could result in serious injuries, serious harm, and/or death).</p> <p>An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:00pm. While the IJ was removed on [DATE] at 4:36 pm, the facility remained out of compliance scoped at isolated with no actual harm and potential for more than minimal harm due to the facility's need to complete in-service training and evaluate the effectiveness.</p> <p>Findings include:</p> <p>Record review of CR#1 face sheet dated [DATE] reflected that he was a [AGE] year-old male that was originally admitted on [DATE]. He had the diagnoses of Sepsis, muscle weakness, hyperlipidemia, pleural effusion, and acute respiratory failure with Hypoxia.</p> <p>Record review of CR #1's care plan dated [DATE] reflected that CR#1 is a high fall risk and that his call light should be kept in reach and that his needs should be responded to in a prompt manner.</p> <p>In an interview with CNA-A on [DATE] at 12:29pm she stated that on [DATE] at around 7pm following a report from the outgoing CNA, she checked on CR#1 and he was in the bed safely and his gown was on and his call light was in reach. She started to provide care for other residents and at 8:00pm she told RN-A that she was starting showers and she needed her to monitor the call lights and to help any of the residents that might need help. CNA-A said that after she was preparing to shower CR#1 when she noticed that his door was closed. She said that she went in his room and CR#1 was laying on the floor in a prone position She said that he was unresponsive and that she immediately called for help. She said that it was approximately 10:45pm when she discovered CR#1 on the floor. She said that help arrived and that when they turned CR#1 over his body was cold and stiff.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 676201	If continuation sheet Page 1 of 6

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview with the Administrator on [DATE] at 1:15pm she said that it's her facility policy that residents are rounded on at least once every 8 hours. She said that the DON of nursing could give more information about rounding because that is her area that she supervises.</p> <p>In an interview with the DON on [DATE] at 1:18pm, DON stated it is the goal and expectation that every resident is rounded every two hours. She said that rounding every two hours helps ensure that residents needs are being met, risk of falls are reduced, and that incontinent care is being provided.</p> <p>In an interview with RN-A on [DATE] at 1:30pm RN-A stated she was called to the resident's room by the CNA-A around 10:45 on [DATE]. On getting there, the resident was found lying face down on the floor non-responsive, with his head slightly turned to the left with his raised hand obstructing part of face. The resident was found nude with a brief around his ankles. There was a small amount of blood on his head, and on his fingers, and several small drops of blood on the floor. We called for help, crash cart was brought in and the patient was put on the back board to initiate CPR, noting no rise and fall of chest. Manager on duty called 911. Laying supine on the back board, the patient's head was unable to touch the floor, and a bit stiff, and appears a postmortem rigidity have set in. On arrival, EMS did not initiate CPR, noticing the DNR wrist band from the hospital and the patient already in the rigor mortis stage. The PPD officer provided the Manager on duty with the case number 25000441 and the time of death as 11:02.</p> <p>In an interview with LVN-A on [DATE] at 1:50pm LVN-A said that she received a call to come to room [ROOM NUMBER] right away to assist staff. She said that when she arrived at room [ROOM NUMBER], she saw patient laying on the floor. She said that she yelled to RN-A and asked if the patient was a full code. She said that she then ran down the hall to call EMS. She said that when she returned to room [ROOM NUMBER], she saw that RN-A and CNA-A had turned the patient on his back. She said she noticed that there wasn't any rise or fall of the patient's chest and that it appeared that postmortem rigidity had set in. She said that the patient's neck was stiff and unable to touch the floor while he was laying supine. She said that EMS arrived and did not initiate CPR because rigor mortis and there was a DNR wristband on the patient's wrist.</p> <p>In an interview with the facilities Medical Director on [DATE] at 12:02pm he said that he did receive a message that CR#1 had passed away on [DATE]. He said that he had not had a chance to assess CR#1 before he passed away. He said in his 12yrs as being a Doctor in America that it takes several hours for rigor mortis to set in a human body.</p> <p>Record review of EMS report dated [DATE] reflected that EMS arrived at the facility and CR#1 was found on the floor and not breathing. His skin was cyanotic, mottled, cold lividity and swelling and bleeding was seen on the head and face of CR#1. EMS staff also noted that CR#1 had rigor mortis to hands, and back. EMS confirmed that CR#1 was DOS at 11:02pm and the scene was turned over to Pearland PD.</p> <p>Record review of the facility's routine resident checks policy dated ,d+[DATE] reflected that:</p> <p>1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each unit at least once per each 8-hour shift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review on [DATE] reflected that this training did occur on [DATE].</p> <p>4. The Director of Nursing, or her equivalent, will review the logs weekly to ensure compliance with safety audits and the fulfillment of each resident's safety measures.</p> <p>Record review on [DATE] reflected that this training/in-service did occur on [DATE].</p> <p>5. The findings of these weekly reviews will be reported during the monthly QAPI (Quality Assurance and Performance Improvement) meetings. If necessary, the QAPI team will initiate changes and retrain staff accordingly.</p> <p>Record review was conducted on [DATE] and it reflected that a QAPI team was in serviced on [DATE].</p> <p>-----</p> <p>1:45pm-Interview with LVN-B on [DATE] LVN-B was able to tell me that she had been in serviced on fall risks, documentation of falls, fall prevention, frequent rounding, and assessments of residents.</p> <p>1:53pm-Interview with CNA-B on [DATE] CNA_B said that she had been recently in serviced that staff need to frequent rounds more, meaning every two hours or as needed depending on the resident. She was able to tell me that if a resident is a fall risk, then the resident's bed should be in lowest position and falls mats may be placed next to the resident's bed.</p> <p>2:00pm-Interview with CNA-C on [DATE] CNA-C told me that he had been in serviced on rounding more frequently at least every two hours or [NAME] depending on the resident. He also was able to tell me that if a resident is a fall risk their bed should be in lowest position and fall mats may also be placed next to their bed.</p> <p>2:05pm-Interview with CNA-D she told me that her in-service was about rounding frequently and more depending on the residents. And that if a resident has a fall, they should not move the resident until they have been assessed.</p> <p>2:22pm-Interview with LVN- C on [DATE] LVN-C said that she had been in serviced on frequent rounding, charting fall prevention, and assessment.</p> <p>2:35pm-Interview with CNA-E on [DATE] CNA-E told me that her in service was about frequent rounding and at least every two hours or [NAME] depending on the condition of the resident. She was also able to tell me that a resident should not be moved until and assessment has been performed.</p> <p>2:40pm-Interview with CMA-A on [DATE] CMA-A said that when she is passing out meds, she makes sure to watch to see if any residents or in distress. She said that her in-service was about frequent rounding. She also said that if a resident is on the floor, then that resident should not be moved before being assessed.</p> <p>2:45pm Observations were conducted on [DATE] throughout the facility. Staff were attending to resident's needs; call lights were being answered and services were being provide to residents.</p> <p>(continued on next page)</p>		

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