STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676239	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER: Villa Toscana at Cypress Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 15015 Cypress Woods Medical Dr Houston, TX 77014	

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 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** 47722 Based on observation, record reviews, and interviews, the facility failed to ensure a resident's environment remained as free of accidents and hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 5 residents (Resident #1) reviewed for transfers in that: - CNA A failed to provide incontinence care with another staff member when Resident #1 required assistance of 2 staff, which resulted in the resident rolling off the bed on 8/19/24, sustaining a right femur fracture, and requiring surgery. An Immediate Jeopardy (IJ) was identified on 9/30/24. The IJ template was provided to the facility on [DATE] at 2:46p.m. While the IJ was removed on 10/1/24 at 2:50p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm, with the potential for minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for falling out of bed, injuries, and hospitalization . Findings included: Record review of Resident #1's undated face sheet indicated she was an [AGE] year-old female admitted to the facility on [DATE]. She had diagnoses of aftercare following joint replacement surgery, cognitive communication deficit, muscle weakness, vascular dementia, osteoporosis, displaced fracture of lower end of right femur, right artificial knee joint, difficulty in walking, type 2 diabetes, and Alzheimer's disease. Record review of Resident #1's Annual MDS assessment dated [DATE] indicated a BIMS was unable to be performed due to her medical conditions. The resident was severely impaired with cognitive skills for daily decision making and never/rarely made decisions. She was dependent (staff does all the work and resident does none of the work. Or resident requires 2 or more staff members) with all ADLs. The resident was always incontinent of bowel and bladder. The MDS indicated she had a hip and knee replacement. The MDS did not have Resident #1's fall on it. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676239	A. Building B. Wing	10/01/2024

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan dated 9/13/24 revealed a Focus: The resident is at risk for falls r/t unaware of safety needs with an actual fall (Initiated: 2/23/21, Revised: 9/17/24). Goal: The resident will be free of falls through the review date. The resident will not sustain serious injury through the review date (Initiated: 2/23/21, Revised: 9/15/24, Target: 12/13/24). Interventions: Resident with actual fall during care. Resident rolled and was guided to the floor mat by CNA A. Resident sent to the hospital (Initiated: 8/19/24). Focus: The resident had a fracture after a fall (Initiated: 7/16/21, Revised: 9/17/24). Goal: Resident's surgical incision will heal without s/sx of infection or breakdown by review date (Initiated: 9/17/24, Revised: 9/17/24, Target: 12/13/24). Interventions: Change surgical incision dressing as per order and PRN (Initiated: 9/17/24). Focus: Resident has an ADL self-care performance deficit. Goal: Resident will demonstrate the appropriate use of adaptive devices to increase ability in bed mobility through the review date (Initiated: 12/22/23, Revised: 9/15/24, Target: 12/13/24). Interventions: Bed Mobility: requires staff x2 for assistance (Initiated: 12/22/21). Record review of Resident #1' s undated Kardex (information about how to care for the resident in the EMR), indicated she required 2 staff assistance for bed mobility. Record review of Resident #1's nursing note dated 8/19/24 at 6:55am, revealed the resident rolled off the bed and on to the floor while CNA A performed bed side care. Record review of Resident #1's fall-risk assessment dated [DATE] at 6:57am, indicated she was a high fall risk. Record review of Resident #1's nursing note dated 8/19/24 at 9:04am, indicated there was a new order for an x-ray for her right knee and right leg r/t pain and the fall. Record review of Resident #1's fall nurses note dated 8/19/24 at 10:46pm, indicated she had bruises to her BLE that were blue/purple. Record review of Resident #1's SBAR dated 8/19/24 at 10:56pm, indicated she had a fracture of the distal shaft (part of her femur by her knee) of her right femur and MD O ordered her to be sent to the ER. Record review of Resident #1's hospital records dated 8/20/24 at 1:03pm, indicated she had a comminuted (broken in 3 or more places) right femoral (thigh bone) fracture extending along the medial lateral (inside and outside) margins of the femoral component (part of the thigh bone that goes into the knee) of the knee arthroplasty (knee replacement). Record review of Resident #1's hospital records dated 8/21/24 at 11:51am, indicated she would need surgery for her right femur fracture, along with revision of her right knee arthroplasty (knee replacement). Record review of Resident #1's hospital records dated 8/25/24 at 10:28am, indicated the resident had a right open reduction internal fixation (repairing fractured bone using plates, screws or rods to stabilize the bone) of her femur on 8/22/24. (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 9/29/24 at 12:26pm, Resident #1's family member said she had fallen out of bed twice in the last month and 10 times in the last year. He said it always happened early in the morning or late at night. He said Resident #1 was non-verbal and bedbound and the last time she fell was when a staff member was changing her and she rolled out of bed onto the floor. During an interview on 9/29/24 at 2:18pm, LVN B said he observed Resident #1 on her back on the floor, next to her bed, on 8/19/24. He said there was 1 CNA who had provided care and he thought the resident was a 1-person assist. During an interview and observation on 9/29/24 at 3:25pm, Resident #1 was laying on her back in bed. The bed was in the lowest position. Resident #1 said she was not having any pain at that time. During an interview on 9/29/24 at 3:35pm, CNA C said the way she knew if a resident was a 2-person assist, was based on the need of the resident, the weight, and the experience of the CNA. She said if a resident had to be a 2-person assist it would be listed in the POC/Kardex. She was not sure if Resident #1 was a 2-person assist. During an interview on 9/29/24 at 3:40pm, CNA D said if a resident was a fall risk and/or a 2-person assist it would be noted in their POC/Kardex. She said Resident #1 was a 2-person assist and she would never change her without another person because the resident could fall. During an interview on 9/29/24 at 3:48pm, CNA E said if a resident is a fall risk and their mobility status, would be on their Kardex. She said if a resident was a 2-person assist and there were not 2 CNAs, then a nurse or some other staff member could assist. She said if only 1 person assists a resident when they need 2 people, they could fall. During an interview on 10/2/24 at 3:15pm, CNA A said Resident #1 rolled off the bed when she turned her away from her during incontinence care. She said at the time, she thought the resident was a 1-person assist and did not know the resident was a 2-person assist. She said she knew to look at the Kardex for mobility and transfer information, but she never thought to look, and it was a mistake. Record review of the facility's policy titled Safe Patient Handling dated 12/30/05 indicated: The facility has a program to promote and assure safe patient handling for both the resident and the employee. The policy includes identification, assessment and interventions to provide a comfortable, safe transfer, repositioning and resident movement. Nurses will identify residents in need of transfer, repositioning, or movement assistance. Nurses will assess the risks associated with lifting, transferring, repositioning or movement assistance. Nurses will be educated in the identification, assessment and control of risks of injury to resident and nurses during patient handling. Resident will be evaluated on admission and as needed for alternative means of lifting, transferring, repositioning and other movement to minimize risk of injury. Nurses will be educated regarding correct safe handling procedures, to report concerns or the inability to perform resident handling or movement that the nurse believes in good faith will expose a resident or nurse to an unacceptable risk of injury. Facility staff will report to supervisor the inability to complete resident lifting, transfer, or repositioning if they feel it will either endanger the resident or cause injury to staff. Nursing will request therapy disciplines to evaluate resident ability to assist and amount of assistance needed with lifting, repositioning, transferring or mobility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy (IJ) was identified on 9/30/24. The IJ template was provided to the facility on [DATE] at 2:46pm. The Plan of Removal was accepted on 9/30/24 at 6:09pm. The plan of removal reflected the following: Interventions: A head-to-toe assessment on resident #1 was completed as of 9/30/24. No additional injuries or complaints of pain were noted. Bilateral grab bars were installed on the bed for resident #1 to assist with turning and repositioning on 9/30/24. As of 9/30/24, The Administrator and DON was 1:1 in-serviced by the Regional Compliance Nurse on 9/30/24 on the topics below. Then CNA A was in-serviced 1:1 by the DON on the following topics below: Completion date 9/30/24. o Following the Kardex in [EMR system] for required assistance with bed mobility. How t o locate the Kardex and determine the staff needed for bed mobility and other ADLS. o Abuse and Neglect (failure to provide the proper number of staff for bed mobility could result in neglect). o Fall Prevention Policy This in-service will include reporting to the charge nurse immediately if a resident suffers a fall, has an accident, or is found on the floor or if CNA must assist a resident to the floor. If the charge nurse is not available, staff will report to the DON immediately. o Safe Handling- the resident will be positioned in the center of bed prior to be turned for care. The other staff member will be positioned on the other side of the bed to prevent the resident from rolling off the bed. o Notification of change in condition- if a resident reports pain or suspected injury, the charge nurse, DON, and/or Physician will be notified. As of 9/30/24 head to toe skin assessments were initiated on all residents in the facility by the DON/ADON/Tx Nurse for any injuries and/or fractures. No additional issues were found. Completion date will be 10/1/24. On 9/30/24, all residents in the facility were assessed and evaluated for assistance with bed mobility by the DON/ADON and Director of Rehab. On 9/30/24, all resident care plans were reviewed for accuracy of assistance needed for bed mobility by Regional Compliance Nurse, DON, and ADON. No issues were identified. The medical director was notified of the immediate jeopardy on 9/30/24 by the Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ad hoc QAPI was held with the Medical Director and facility interdisciplinary team on 9/30/24 to discuss the immediate jeopardy and subsequent plan of removal. In-services: The DON and ADON then initiated in-servicing all nursing staff on the following topics below as of 9/30/24. All staff not present will not be allowed to assume their duties until in-serviced.?All new hires will be in-service on their date of hire, during facility orientation. All agency staff will be in-serviced prior to start of their assignment. o Following the Kardex in Point Click Care for required assistance with bed mobility. How to locate the Kardex and determine the staff needed for bed mobility and other ADLS. o Abuse and Neglect (failure to provide the proper number of staff for ADLs could result in neglect). o Fall Prevention Policy This in-service will include reporting to the charge nurse immediately if a resident suffers a fall, has an accident, or is found on the floor or if CNA must assist a resident to the floor. If the charge nurse is not available, staff will report to the DON immediately. o Safe Handling- the resident will be positioned in the center of bed prior to be turned. The other staff member will be positioned on the other side of the bed to prevent the resident from rolling off the bed. o Notification of change in condition- if a resident reports pain or suspected injury, the charge nurse, DON, and/or Physician will be notified. On 10/1/24 a monitoring visit was conducted to ensure the facility was following its POR. The visit revealed: Record review of Resident #1's skin assessment performed by the DON on 9/30/24 at 3:18pm, indicated bruising was found on the R hand, L hand, and R 1st and 2nd toe. Resident #1 had a healed incision to her L and R knee, a rash under both breasts, and an abrasion to the L and R thigh. Record review of Resident #1's bed rail assessment performed by the DON on 9/30/24 at 4:10pm, indicated bilateral 1/3 rails would be used for turning side to side and holding herself to one side. Record review of Resident #1's bed rail consent from the [family member] on 9/30/24 at 4:11pm, indicated it was for bilateral 1/3 partial rails. Record review of in-services dated 9/30/24 given to the ADM by the Regional Compliance Nurse, reflected Notification of Fall/Injury to Regional Compliance Nurse: To ensure she reaches out to the Compliance Nurse to go over falls/injuries to ensure policies/procedures are being followed accurately and timely, Following the Kardex in [EMR system] for Required Assistance with Bed Mobility, How to Locate the Kardex and Determine Staff Needed for Bed Mobility and Other ADLs, ANE, Fall Prevention Policy, Safe Handling, and Notification of Change in Condition. (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 in-services dated 9/30/24 given to the DON by the Regional Compliance Nurse, reflected Notification of Fall/Injury to Regional Compliance Nurse: To ensure she reaches out to the Compliance Nurse to go over falls/injuries to ensure policies/procedures are being followed accurately and timely, Following the Kardex in [EMR] for Required Assistance with Bed Mobility, How to Locate the Kardex and Determine Staff Needed for Bed Mobility and Other ADLs, ANE, Fall Prevention Policy, Safe Handling, and Notification of Change in Condition. Record review of in-services dated 9/30/24 given to CNA A by the DON reflected, Following the Kardex, ANE, Fall Prevention Policy, Safe Handling, and Notification of Change. Record review of head-to-toe skin assessments dated 9/30/24 performed by the DON/ADON/Treatment Nurse, reflected all 87 resident assessments were completed on 10/1/24. 2 residents were found with new skin issues. 1 resident had new skin tears to Bil knees and R shin. The other resident had new rashes to her lower back and the back of her Bil knees. Record review of assistance with bed mobility dated 9/30/24 assessed by the DON/ADON and Director of Rehab, reflected no new residents were found with mobility concerns, and no changes needed to occur with the current mobility of residents. Record review of care plans dated 9/30/24 assessed by the Regional Compliance Nurse, DON, and ADON, reflected no issues found with any care plans. Record review revealed the Medical Director was notified of the IJ on 9/30/24 by the ADM. Record review of the Ad Hoc QAPI meeting dated 9/30/24 reflected the Medical Director, ADM, DON, ADON, SW, Dietary Manager, Activities Director, Maintenance Supervisor, Director of Rehab, and all other appropriate members were in attendance. Record review of in-services dated 9/30/24 to all nursing staff, reflected the Kardex, ANE, Fall Prevention, Safe Handling, and Notification of Change in Condition. As of 9:30am on 10/1/24 100% of the nursing staff had completed in-services either in person or over the phone. During an interview on 10/1/24 at 11:39am with the ADM, she said she received in-services on ANE, Reporting, Kardex, Fall Prevention, Safe Handling, and COC. She received in-services on what COC means. She received in-services on ANE and the different types of abuse which were: physical, mental, sexual, and misappropriation. She said if she were to see any ANE she investigated, suspended the staff member, and reported to her superiors. She said the Kardex was the resident's plan of Care and had their mobility, assistance, skin issues, and diets on it. The ADM said she was in-serviced on falls and interventions like, fall mats and non-slip footwear. Safe handling was also in-serviced which was 2 person transfers, pulling the resident towards yourself when changing. COC was vomiting, coffee ground emesis, blood in the stool, or change in mobility. If the ADM were to see a COC, she would notify the DON. (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 10/1/24 at 11:32am with the DON she said she received in-services on mechanical lift transfers, and gait belt transfers, ANE and the different types like, physical, mental, misappropriation, neglect, and sexual. She said if she were to see any ANE she would report to the Abuse Coordinator (ADM). She received in-services on how to use the Kardex and what was on it like, mobility, fall prevention, and ADLs. She also was in-serviced on fall prevention and who to notify and Safe Patient Handling, which was having 1 person on each side of the bed and centering the resident in the bed. COC in-services were also given which could be pain, injury, bruises, or anything changed from baseline. If there was a COC staff were to notify the Charge Nurse or herself. During an interview on 10/1/24 at12:42pm with CNA A she said she received in-services on notification of changes, the Kardex, mechanical lifts, ANE, Fall Prevention, and Safe Handling. She said safe handling was positioning the resident in the center of the bed and having 1 person on each side of the bed when changing a resident. She said the Kardex had toileting, and information you need to take care of the resident like, transferring. She said the different types of ANE were physical, mental, and sexual. She said she would report to the ADM (Abuse Coordinator). She said if a resident was falling and was guided to the floor, it was still a fall. CNA A said she would report to a fall to the Charge Nurse, and if she was not available then the DON. During an interview on 10/1/24 at 10:02am with CNA F she said she received in-services on mechanical lifts, who to call when there was a fall, following the Kardex, abuse/neglect, safety handling, and fall prevention. She said the different types of ANE were physical, mental, sexual, and misappropriation. If she were to witness any she would report to the DON/ADM (Abuse Coordinator). She said safe handling was always having 2 people to assist the resident if they required it and having the resident in the center of the bed during care. She said she would report a fall/COC to the Charge Nurse/DON. CNA F said the Kardex had the resident's diet, how many staff members it took to transfer/take care of the resident, and any information needed to take care of a resident. During an interview on 10/1/24 at 10:10am with CNA G she said she had in-services on fall prevention, transfers, ANE, 2-person transfers, positioning, notification of change, safe handling, and the Kardex. She said the Kardex had information on how to transfer residents or if they were a 2-person assist, their mobility, how to take care of them, and their ADLs. She said the different types of ANE were verbal, physical, mental, misappropriation, and isolation. She would report to the ADM (Abuse Coordinator) if she ever saw any. CNA G said she would report a fall to the Charge Nurse immediately or the DON. She said safe handling was ensuring the resident was positioned properly in bed, ensuring the resident was centered in bed, pulling the resident towards you before turning, and making sure there was a second person to help. If she noticed a COC, she would notify the Charge Nurse. During an interview on 10/1/24 at 10:22am with CNA H she said she received in-services on gait belts, transferring, mechanical lifts, fall prevention, COC, who to report to, Kardex, ANE, and safe handling. She said the Kardex had information about if the resident required 2 person transfers, their mobility, diet, and how to take care of the resident. She said the different types of ANE were physical, verbal, sexual, seclusion, and misappropriation. If she were ever to see any ANE she would report to the ADM (Abuse Coordinator). She said safe handling was using 2-persons if needed and positioning the resident correctly in bed. If she saw a COC, she would notify the Charge Nurse or the DON. If she found a resident who had fallen, she would not move the resident, and get the nurse/DON. (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 10/1/24 at 10:30am CNA I said she had in-services on the Kardex, transfers, ANE, reporting falls to the Abuse Coordinator, and safe handling. She said safe handling was positioning the resident in the center of the bed when providing care, pulling them towards you, and having 2 people assist. The Kardex: had information on how many people it took to transfer, how they ate, their mobility, toileting, and ADLs. She said the different types of ANE were physical, mental, exploitation, and neglect. She said she would report to the nurse, ADON, and ADM (Abuse Coordinator) if she were ever to see any ANE. If she saw a fall she would get the nurse, would not move the resident, and would get the DON if the Charge Nurse was not available. She said a COC was something different on the skin, pain, seeing something that was different from baseline, or not eating. She would notify the nurse/DON. During an interview on 10/1/24 at 11:00am CNA J said she received in-services on transfers, mechanical lifts, gait belts, ANE, turning/positioning, 2-person assist, COC, and the Kardex. She said the Kardex had information about how many people were needed for turning/mobility, and ADLs. She said examples of ANE were physical, mental, verbal, sexual, neglect, and misappropriation. If she were to see ANE she would inform the Charge Nurse/ADM (Abuse Coordinator). If she were to witness a fall, she would notify the nurse and would not move the resident because they could have broken bones. She said a guided fall was still a fall. She said safe handling was putting the resident in the middle of the bed, having 2 people, making sure there was enough room to turn the resident, and always using 2 people with mechanical lifts. She said if she noticed a COC, she would notify the Charge Nurse/DON. A COC could be redness, bruising, skin tear, rash, bed sore, or a change in mood. During an interview on 10/1/24 at 11:04am Med Aide K said she had in-services on mechanical lifts, transfers, 2-person assist, safe handling, ANE, the Kardex, and COC. She said safe handling was having 2 people assisting the resident, having the resident in the center of the bed, and having the resident face you when turning them. She said the different types of ANE were physical, verbal, and neglect. If she saw any ANE she would notify the Abuse Coordinator (ADM). The Kardex had information on it like the resident's mobility, their amount of assistance needed, and ADLs. She said a COC could be pain or not urinating and she would notify the Charge Nurse or the DON. During an interview on 10/1/24 at 11:17am CNA L said she had in-services on fall prevention, transferring, person assist, the Kardex, ANE, and safe handling. She said the Kardex had information about the resident's transferring assistance, mobility, and ADLs. She said examples of ANE were physical, mental, verbal, and sexual. If she were to see ANE she would report to the Charge Nurse, the DON, and the Abuse Coordinator (ADM). She said if she had a resident who had fallen, she would notify the nurse and would not move the resident. If the nurse was not available, she would notify the DON. She said safe handling was taking a second person or nurse to change the resident and pulling the resident toward you. A COC could be skin tears, bruising, or anything out of the normal and she would report it to the Charge Nurse and the DON. During an observation on 10/1/24 at 1:46pm Resident #1 was asleep on her back in bed. The bed was in the lowest position and there were bil side rails up on the bed. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 10/1/24 at 2:00pm LVN B said he had in-services on ANE, transferring residents, mechanical lifts, 1-2 person assists, COC, the Kardex, fall prevention, and safe handling. He said the different types of ANE were physical, verbal, mental, and misappropriation. He said he would report ANE to the Abuse Coordinator (ADM). He said the Kardex was a care plan for each resident, and had transferring, and ADLs on it. He said safe handling was having 1 person on each side of the bed during resident care, positioning yourself and the resident safely, and turning the resident towards yourself if alone. A COC was any change from baseline like, confusion, or agitation. He would notify the MD and perform an SBAR. If a resident were to fall, he would assess the resident on the spot, get vitals, and notify the MD. He said he would start neuro checks if the fall was unwitnessed and continue even when the resident comes back from the hospital. During an interview on 10/1/24 at 2:14pm LVN M said she received in-services on transfers with Hoyer lifts and gait belts, ANE, safe handling, the Kardex, COC, Falls, and ANE. If a resident had a COC, she would notify the DON and the CNAs notify her. If a resident had a fall, she would notify the DON and the ADM. She said examples of ANE were physical, emotional, misappropriation, mental, sexual, neglect and she would report it to the DON and ADM (Abuse Coordinator). She said the Kardex had the resident's transfer status, mobility, and ADLs. She said safe handling was having 1 person on each side of the bed and rolling the resident toward you. During an interview and observation on 10/1/24 at 2:32pm CNA N and CNA F were observed performing incontinence care on a resident who was a 2 person assist. The resident was centered in the bed. CNA F pulled the resident toward her and then turned her toward CNA N. When the resident was clean, the resident was pulled toward CNA N and turned toward CNA F. After the resident was finished, she was centered back in the bed. The CNAs explained the process during the procedure and the resident remained safe the whole time. An Immediate Jeopardy (IJ) was identified on 9/30/24. The IJ template was provided to the facility on [DATE] at 2:46pm. While the Regional Nurse Consultant was notified the IJ was removed on 10/1/24 at 2:50pm, the facility remained out of compliance at a severity of no actual harm with the potential for minimal harm, that is not immediate jeopardy with a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.