

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER The Wesleyan Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4011 Williams Dr Georgetown, TX 78628	
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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on interviews and record reviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 6 residents reviewed for falls. The facility failed to put assessments and/or neuro checks in place for Resident #1 after she was sent to the ER after a fall on 03/12/25 at approximately 6:00 a.m. and returned to the facility on [DATE] at approximately 10:23 a.m. with diagnoses of an orbital floor fracture, lip or mouth laceration (cut through the skin), hematoma (collection of blood trapped outside of a blood vessel (bruise or a contusion)) to the left side of her head, and a maxillary sinus (midface) fracture. An IJ was identified on 03/14/2025. The IJ template was provided to the facility on [DATE] at 9:20 p.m. While the IJ was removed on 03/15/25, the facility remained out of compliance at a scope of isolated and a severity of potential for more than minimal harm because of the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving necessary medical care, a change in condition, harm, and hospitalization . Findings include: Review of Resident #1's Admission Record, dated 03/14/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses including dementia, hypertensive chronic kidney disease (occurs when chronic high blood pressure damages the kidneys leading to a decline in function), epilepsy (a chronic brain disorder characterized by recurrent seizures), cognitive communication deficit, other speech disturbances, generalized muscle weakness, need for assistance with personal care, other abnormalities of gait and mobility, other chronic pain, muscle wasting and atrophy, stroke, unspecified osteoarthritis (a common joint disease that causes pain, stiffness, and loss of function), and age-related physical debility. Review of Resident #1's Annual MDS, dated [DATE], reflected she had a BIMS score of 6, which indicated she had severe cognitive impairment and had 2 falls with no injury during her admission at the facility. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #1's Care Plan, initiated 07/14/20, reflected she had a history of actual falls and had a witnessed fall resulting in a laceration to her lip and swelling to her left cheek on 03/12/25. Staff were required to check range of motion for the next 72 hours, monitor/document/report as needed and for the next 72 hours to the MD for signs and symptoms of pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, and agitation, and conduct neurological checks for the next 72 hours. Review of Resident #1's Progress Notes reflected: -A note created by LVN A on 03/12/25 at 9:05 a.m. that reflected Resident #1 had a witnessed fall, had swelling and bleeding from the left side of her cheek and face, was sent to the hospital ER for evaluation, and had moderate to severe cognitive impairments. LVN A was required to conduct an initial assessment, followed by every 15 minutes four times, every two hours post-incident (x4), and every shift for the next 72 hours. There were no notes in the neurological check note text box. -A note created by LVN A on 03/12/25 at 9:03 a.m. that reflected, Resident was getting out of bed ready by CNA to get in the wheelchair and resident was on the side of the bed when resident swung at CNA, the CNA turned her back to resident and when CNA turned back resident had fell to the floor hitting her face. Head to toe assessment completed at this time, noticed puddle of blood on the floor by resident left cheek, cleansed area best as could and had resident apply towel to site to stop bleeding. EMS called at time of accident to send resident out as left cheek was swelling and continuing to bleed. EMS arrived and transferred resident to Hospital ER for evaluation. RP notified of situation. -A note created by LVN A on 03/12/25 at 10:34 a.m. that reflected, Resident returned to facility at this time from hospital by EMS stretcher. Cleaned up resident at this time and applied clean clothes on, resting comfortable in bed, stitches on lip intact, denies any pain at this time. -A note created by RN D on 03/12/25 at 4:05 p.m. that reflected Resident #1 had a witnessed fall, had a lacerated lip, stitches, swollen left side of her face, and bloody drainage by mouth, remained in bed on 03/12/25, had severe cognitive impairment, had stable vital signs and complaint of pain in her face, and staff were required to continue to monitor post-ER visit. RN D was required to conduct an initial assessment, followed by every 15 minutes four times, every two hours post-incident (x4), and every shift for the next 72 hours. -A note created by the VPO on 03/12/25 at 6:21 p.m. that reflected, Additional information when officer was in room. DON witnessed in front of officer introducing that someone was here to visit. Resident was lying in bed with head slightly turned to the right. Resident with noted bruising and swelling to left side of face with sutures present to lip. Left eye swollen. DON asked resident if she was in pain and responded no twice when asked. Resident remains under observation for fall. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-A note created by RN D on 03/12/25 at 9:34 p.m. that reflected, Resident was given tramadol 50 mg po at 1450 for mild pain. Resident was able to swallow with some difficulty. She drank water from the cup, but some spilled out of her mouth with bloody drainage. Resident's mouth continued to ooze blood with some drying on a towel that was placed under her chin. The CNA reported removing clots from her mouth at one point. At dinner, she was spoon-fed but did not eat much. Her meds were crushed and put in pudding, which she swallow and drank a small amount of Boost with a spoon, being fed by the CMA. She continued to sleep all evening. She was evaluated by the DON due to continued bleeding, who then spoke with NP and received further orders. After dinner, her oral bleeding seemed to stop. The towel remained clean under her chin. HS blood sugar was 168 and due to her history of hypoglycemia at night and her not eating, her HS Basaglar was held at the nurse's discretion. I gave her the rest of the Boost container by her PEG , along with the new order of 1000mg of acetaminophen. Amoxicillin started per orders this pm. Resident resting, vital signs stable, stitches intact. -A note created by LVN F on 03/13/25 at 12:05 a.m. that reflected, 11:00 p.m. Resident sleeping. Called her name, no response to staff. 98.2-78-16-88/52 manual-74% on room air. O2 started at 2 liters per minute by nasal cannula. 2nd Nurse in to evaluate blood pressure. Unable to get manual blood pressure. Staff talking loudly to resident, she turned her head toward staff. Asked if she is hurting, moved her head side to side-No. Did not open her eyes. 11:14 p.m. On-Call NP notified. Orders received to transfer to hospital. 911 Activated. 11:20 p.m. EMS on site. 11:40 p.m. Resident transferred to Hospital by EMS. DON notified. 11:43 p.m. Nurse to Nurse report called to Hospital ER, spoke with two nurses. 11:50 p.m. RP notified of change in condition & transfer to Hospital. Review of Resident #1's Hospital Records, dated 03/12/25 at 8:38 a.m., reflected she was seen for an orbital floor fracture, lip laceration, and maxillary sinus fracture. Resident #1's face CT reflected an acute comminuted fracture of the anterior left maxillary sinus and orbital floor which involves the orbital canal, associated hematoma in the left inferior extraconal space without significant mass effect on the intracranial structures, large left facial contusion-hematoma, and a remote nasal bone fracture. Review of Resident #1's Weekly Skin Observation Assessment, dated 03/12/25 at 7:03 p.m. by unknown, reflected her left side of face was swollen and remained reddened after 30 minutes of pressure reduction, a hematoma under her left eye, a bruise on the left side of her face, a cut and on the left side of her lip from the fall. Review of Resident #1's Assessments, dated 03/14/24, reflected Resident #1 had one assessment completed on 03/12/25, which was a weekly skin observation. There were no other assessments completed on 03/12/25. Review of Resident #1's Orders and Order Summary Report, dated 03/14/25, reflected there was no hold order on her Clonidine 1 tablet of 0.1 MG of Clonidine (treats high blood pressure) every eight hours for her hypertension post-fall on 03/12/25. There was a hold on her Clopidogrel Bisulfate (an antiplatelet (blood thinner used to prevent stroke, heart attack and other heart problems)) 1 tablet of 75 MG at bedtime for peripheral vascular disease may crush and give by G-tube. Review of Resident #1's MAR/TAR for March 2024 reflected she was given by mouth 1 tablet of 0.1 MG of Clonidine (treats high blood pressure) unless her systolic blood pressure was less than 110 on the following dates and times: (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/14/25 at 11:34 a.m., LVN A stated on 03/12/25 at 6:30 a.m., CNA C notified her that Resident #1 fell . LVN A explained that CNA C told her that she was trying to apply deodorant to Resident #1, Resident #1 tried to reach for her arm, she twisted to her side, and Resident #1 fell forward from her bed onto her fall mat. LVN A stated she entered Resident #1's room and observed Resident #1 lying on her left side on the fall mat, was bleeding from her mouth and nose, and her left cheekbone started swelling. LVN A stated she asked Resident #1 if she was in pain and Resident #1 told her no. LVN A stated she conducted a head to toe assessment on Resident #1 and observed no other injuries. LVN A stated she applied pressure to Resident #1's nose and notified EMS. LVN A stated she did not take Resident #1's vitals because EMS arrived and took over on the situation. LVN A stated Resident #1 returned from the hospital on 03/12/25 around 10:20 a.m. and she took Resident #1's vitals. LVN A stated she observed Resident #1 had stitches to her lip and a swollen cheekbone. LVN A stated she received the discharge orders, notified the NP that Resident #1 returned from the hospital, and the NP reviewed the discharge orders. LVN A stated she did not initiate neurological assessments on Resident #1 because she forgot. LVN A stated nurses were supposed to initiate neurological assessments on residents whenever there was a fall or if it was unknown whether or not a resident hit their head. LVN A stated she knew the importance of initiating assessments on residents post-fall and said, Residents' blood pressure could drop, a head injury could happen, and a hematoma could develop . During an interview on 03/14/25 at 12:23 p.m., the NP stated on 03/12/25 close to 8:00 a.m., LVN A notified her that Resident #1 had a fall. The NP stated LVN A told her that while a CNA was performing morning care on Resident #1, Resident #1 swung her arm at the CNA, the CNA ducked, Resident #1 fell forward, LVN A observed a pool of blood, and LVN A notified EMS. The NP stated LVN A also notified her that Resident #1 returned to the facility from the hospital on 03/12/25 before lunch (11:00 a.m.-11:30 a.m.). The NP stated she observed Resident #1 before lunch on 03/12/25, reviewed Resident #1's ER records, found Resident #1 was x-rayed while at the hospital and the ER did not give any post-visit recommendations, and told LVN A to monitor Resident #1. The NP explained monitoring was defined as conducting neurological assessments and taking vital signs on a resident. The NP stated the facility was required to perform neurological assessments and take vital signs from a resident after a fall, which was the standard nurse practice. The NP stated she expected the facility nurses to assess Resident #1 every shift. The NP stated she also expected neurological and pain assessments to be performed and vitals to be taken from Resident #1, which was the standard nurse practice. The NP stated she knew the importance of initiating assessments on residents post-fall and said, To check for deterioration. To make sure the resident did not have any decline from the bleeding. Neurological decline. Swallowing decline. That may present itself post-injury. Especially someone on antiplatelet (medications that prevent platelets from clumping together and forming blood clots), which could increase the risk of bleeding due to the injury. [Resident #1] was on an antiplatelet, Clonidine (used to treat high blood pressure), which was held. Blood pressure could drop too. The NP stated she was unaware the facility nurses did not perform neurological assessments on Resident #1 and did not know why the facility nurses did not perform neurological assessments on Resident #1. The NP stated if a resident fell and hit their head, then neurological assessment checks were appropriate. The NP stated if a resident fell and hit their head and went to the ER, then protocol did not pick back up upon return from higher level of care. The NP stated LVN A and the afternoon and night shift nurses should have completed assessments upon Resident #1's return so there would have been at least eight hour checks completed on Resident #1 for the next 72 hours after the fall. The NP stated the on-call NP notified her that Resident #1 was sent back to the hospital on 03/12/25 during the night shift, could not remember why, and believed the reason was due to Resident #1 having low O2. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/14/25 at 1:00 p.m., Resident #1's FAM stated on 03/12/24, LVN A called and notified them that Resident #1 had a minor fall. Resident #1's FAM stated LVN A told them that Resident #1 tried to swing her arm at a CNA while the CNA was getting her dressed and up for the day, the CNA stepped back, Resident #1 fell forward, and was sent to the hospital. Resident #1's FAM stated on 03/12/25 around 10:30 a.m., the facility notified them that Resident #1 returned from the hospital and received stitches. Resident #1's FAM stated they visited Resident #1 at the facility on 03/12/25, who told them that the CNA pissed her off, did not explain how the CNA pissed her off, and made her fall. Resident #1's FAM stated the police were notified and told them that CNA C and LVN A were in the room when Resident #1 fell and Resident #1's head hit the hardwood floor and body hit the fall mat when she fell. Resident #1's FAM stated on 03/12/25 around 11:54 p.m., the facility called and notified them that Resident #1's blood pressure bottomed out and Resident #1 was sent to the hospital. Resident #1's FAM stated they visited Resident #1 at the hospital on 03/12/25 and the hospital staff told them that Resident #1 was x-rayed and had a fracture and blood pulling from her left eye. Resident #1's FAM stated on 03/13/25, the hospital staff told them that Resident #1 had a fractured nose and needed surgery. During an interview on 03/14/25 at 2:11 p.m., LVN B stated on 03/12/25 at 6:30 a.m., LVN A asked her to come and assess Resident #1. LVN B stated she entered Resident #1's room and observed Resident #1 lying on her left side on the fall mat, her head between her bed and nightstand and her right cheekbone was swollen and blood dripping from her nose and notified EMS. LVN B stated she did not perform a head to toe assessment and did not take Resident #1's vitals because she finished her shift and left the facility on [DATE] around 7:30 a.m. LVN B stated she did not know if LVN A took Resident #1's vitals and did an assessment on Resident #1. LVN B stated she returned to the facility on [DATE] around 9:45 p.m. and did not check on Resident #1 at the start of her shift because she had to administer medications to other residents. LVN B stated she later entered Resident #1's room and noticed Resident #1 had low blood pressure. LVN B stated she took Resident #1's temperature, pulse, respiration, blood pressure that read of 88/43, and O2 saturation that read 74%, put Resident #1 on O2, and notified EMS. LVN B stated Resident #1's blood pressure dropped more when EMS arrived and said, It was 50/something else. LVN B stated RN D, who worked the previous shift before she started her shift, did not notify her of needing to perform any neurological assessments or other assessments on Resident #1. LVN B stated nurses performed neurological assessment checks and other assessments on residents. LVN B stated performing neurological assessments and other assessments on residents was the standard with an incident report. LVN B explained a nurse must assess a resident and take a full set of vitals and complete neurological assessments every shift anytime there was a fall and witnessed fall in which the resident hit their head. LVN B stated neurological assessments and other assessments were documented in residents' electronic health records. LVN B stated neurological assessments were performed on a resident every 15 minutes four times, every two hours two times, and then every shift for the next 72 hours. The DON and ADON oversaw to ensure neurological assessments and other assessments were initiated and the frequency of assessments performed was completed. LVN B stated she was trained and in-serviced on conducting neurological assessments annually and whenever there was an incident. LVN B stated she knew the importance of initiating assessments on residents post-fall and said, To get a baseline to see if there was any change in status. There could be permanent damage. LVN B stated neurological assessments and other assessments still have to be performed on a resident even if the resident returned from the hospital and said, You do not know. Still got to watch them for 72 hours at the very least. LVN B stated she was unaware that neurological assessment checks and other assessments were not initiated on Resident #1. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An attempt to call RN D was made on 03/14/25 at 2:30 p.m. A voicemail and call back number were left. RN D did not return the call before exit on 03/15/25. During an interview on 03/14/25 at 3:24 p.m., CNA C stated Resident #1 had past falls at the facility. CNA C stated on the morning of 03/12/25, she was applying deodorant on Resident #1, turned around to reach for the deodorant, she felt something on her back, she turned around, observed Resident #1 lying on her left side on the floor, bleeding from her mouth and nose and screaming, she freaked out, ran, and notified LVN A. CNA C stated she did not see Resident #1 fall because her back was turned. CNA C stated Resident #1's body was on the fall mat and head was not on the fall mat at the time of her fall. CNA C stated LVN A entered Resident #1's room, took Resident #1's vitals, assisted resident #1 up, and notified EMS. CNA C stated Resident #1 returned from the hospital on 03/12/25 around 11:30 a.m. CNA C stated Resident #1 was still bleeding from her face and she tried to dry and place pressure on her face to stop the bleeding until the end of her shift on 03/12/25 at 2:00 p.m. CNA C stated she observed the nurses take Resident #1's vitals and blood pressure three times during her shift. CNA C stated she did not observe the nurses perform neurological assessments and other assessments on Resident #1. During an interview on 03/14/25 at 3:54 p.m., Resident #1's RP stated on 03/12/25 around 7:00 a.m., LVN A called and notified them that Resident #1 had a fall and it was not too bad. Resident #1's RP stated LVN A told them that Resident #1 was standing, a CNA was helping her transfer, Resident #1 swung her arm at the CNA, the CNA stepped back, Resident #1 lost her balance, fell , hit the floor, was fine, head hit the floor, was sent to the hospital to be checked out and LVN A believed it was not that serious. Resident #1's RP stated on 03/12/25 around 10:30 a.m., she called the facility and the Receptionist told them that Resident #1 returned to the facility from the hospital on 03/12/25 at 10:15 a.m. Resident #1's RP stated LVN A called and notified them that Resident #1 had swelling, stitches on her lip, received morphine, and was resting. Resident #1's RP stated they visited Resident #1 at the facility on 03/12/25 and Resident #1 told them that the CNA pissed her off and dropped her on her face. Resident #1's RP stated they did not observe the nurse take any vitals or perform any neurological assessments or other assessments on Resident #1. Resident #1's RP stated an unknown name staff member told them that the CNA tried to transfer Resident #1 on her own without assistance, Resident #1 fell , and the facility was trying to cover up the incident. Resident #1's RP stated the DON told them that Resident #1 was standing, fell , and then changed her statement and told them that Resident #1 was sitting at the side of her bed, the CNA turned her back to get deodorant, Resident #1 reached for the CNA, lost her balance, and fell . Resident #1's RP stated the facility did not tell them that Resident #1 sustained facial fractures from her fall. Resident #1's RP stated a nurse called and notified her that Resident #1's blood pressure dropped low and was sent to the hospital. Resident #1's RP stated they visited Resident #1 at the hospital and hospital staff told them that Resident #1 was x-rayed during her initial hospital visit and was found to have sustained a left orbital fracture and [NAME] fracture from the fall. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/14/25 at 3:22 p.m., the MD stated he did not know if Resident #1 had a history of falls because he started working at the facility one week ago. The MD stated the NP called and notified him that Resident #1 had a fall after she returned from the hospital on 03/12/25. The MD stated the NP told him that Resident #1 was sitting at the edge of the bed, reached out to the CNA, the CNA moved out the way, and Resident #1 fell to the ground. The MD stated he did not provide guidance or instruction to the facility staff other than to follow-up with Resident #1. The MD stated nurses performed neurological assessments and other assessments on residents. The MD stated it takes 6-24 hours before neurological changes start to appear and then leveled off the following two days. The MD stated neurological assessments did not always have to be initiated if a CT evaluation was performed. The MD stated a resident going to the hospital would stop later neurological changes a little but due to the CT scan performed, but residents still needed to be monitored for a change in condition. The MD stated facility staff were required to keep an eye on Resident #1 and he did not have any documentation of the facility staff doing such. The MD stated he did not request facility staff to conduct neurological assessments at the time of Resident #1's fall. The MD stated it would have been reasonable for facility staff to conduct neurological assessments and other assessments in case there was further injury. The MD stated he knew the importance of initiating assessments on residents post-fall and said, In case if there was delayed neurological changes and they could have altered mental status if not performed. The MD stated Resident #1's Clonidine was held upon her return from the hospital on 03/12/25 and said, Because if there's trauma, there's a risk of a small bleed and we want to limit that. During an interview on 03/14/25 at 4:47 p.m., CNA C stated Resident #1's wheelchair was in the restroom and she did not attempt to transfer Resident #1 on her own. During an interview on 03/14/25 at 5:01 p.m., CNA G stated she was not working when Resident #1 fell on [DATE]. CNA G stated she was instructed by the nurses to keep checking on Resident #1, make sure Resident #1's mouth was clean, and to notify the nurse if she was in pain. CNA G stated she did not observe the nurses perform neurological assessments or other assessments on Resident #1. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/14/25 at 5:15 p.m., the DON stated Resident #1 had a history of falls before admission and fell at the facility in the past. The DON stated on 03/12/25 around 6:20 a.m., LVN A called and notified her that Resident #1 fell , was bleeding, she called EMS, and Resident #1 was sent to the hospital. The DON stated LVN A told her that CNA C was getting Resident #1 ready for breakfast, Resident #1 was sitting at the edge of the bed, CNA C turned around to grab Resident #1's deodorant, Resident #1 tried to grab CNA C, fell and her body hit the fall mat and the left side of her face hit the ground, CNA C notified LVN A, LVN A entered Resident #1's room, observed Resident #1 was bleeding from her mouth, called EMS and applied an ice pack to Resident #1's face. The DON stated staff did not notify her that Resident #1 was bleeding from her nose after the fall and she was unsure if Resident #1's fall was witnessed or unwitnessed. The DON stated she did not ask LVN A if she performed any assessments on Resident #1 before EMS arrived. The DON stated LVN A performed a head to toe assessment on Resident #1 in the incident report. The DON stated LVN A notified her on 03/12/25 at 9:00 a.m.-9:30 a.m. that Resident #1 was returning from the hospital. The DON stated Resident #1 returned to the facility from the hospital on 03/12/25 around 10:00 a.m. The DON stated she reviewed Resident #1's discharge orders and found Resident #1 had a CT evaluation completed at the hospital that found Resident #1 sustained an orbital fracture and maximal fracture from the fall. The DON stated she was unsure when the NP and MD were notified and believed they were notified when Resident #1 returned to the facility from the hospital. The DON stated the NP and MD told staff to keep monitoring Resident #1. The DON explained monitoring was defined as checking vitals, observing for a change in condition, constantly entering Resident #1's room, and tending to Resident #1's pain. The DON stated the nurses performed neurological assessments and other assessments on Resident #1 and did not document the assessments completed. The DON stated the nurses documented the assessments on residents' electronic health records and physical sheets. The DON stated she was responsible for overseeing and ensuring neurological assessments and other assessments were initiated and completed to ensure they were initiated and performed according to the frequencies. The DON stated she believed she in-serviced staff on completing assessments sometime in 2025. The DON stated nurses must initiate neurological assessments and other assessments whenever a resident had an unwitnessed or witnessed fall in which they hit their head and are taking blood thinning medication every 15 minutes four times, every two hours four times, and every shift for the next 72 hours. The DON stated it took approximately some hours before a neurological change or a change in condition to appear. The DON stated Resident #1 took Plavix (blood thinning medication) before her fall on 03/12/25. The DON stated she knew the importance of initiating assessments on residents post-fall and said, In case the resident had an internal injury. Resident could have a critical condition if not monitored. The DON stated a hospital transfer did not stop residents from having neurological changes or change in condition because some changes stop immediately and some take longer to stop. The DON stated on 03/12/25 around 11:40 p.m., LVN F called and notified her that Resident #1 was sent back to the hospital due to low blood pressure of 88/something. The DON stated the nurses checked and documented Resident #1's blood pressure on a physical sheet and they did not input the entries into Resident #1's electronic health records. The surveyor asked the DON for the physical sheets reflecting the nurses blood pressure checks on Resident #1. The DON stated she could not provide the physical sheets reflecting the nurses blood pressure checks on Resident #1 to the surveyor and did not provide a reason when the surveyor asked. The DON stated Resident #1 was unable to explain how she fell . She did not constitute Resident #1's incident as neglect because CNA was in the room when Resident #1 fell and she did not consider it neglect even if CNA turned her back, Resident #1 reached out, and Resident #1 fell . (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/14/25 at 6:25 p.m., the ADM stated on 03/12/25 around 9:00 a.m., the DON notified her that Resident #1 had a fall and was sent to the hospital. The ADM stated the DON told her that CNA C was in the room with Resident #1 when Resident #1 fell and hit her head and Resident #1 returned to the facility from the hospital with a laceration and sutures. The ADM stated CNA C told her that on 03/12/25 around 6:00 a.m.-6:30 a.m., she was getting Resident #1 ready, Resident #1 was sitting on the bed, she was applying deodorant on Resident #1, Resident #1 tried to swing her arm at her, she turned to get something, Resident #1 was lying on the fall mat, and she went and notified LVN A. The ADM stated CNA C did not tell her whether or not Resident #1 was completely on the fall mat. The ADM stated LVN A told her that CNA C was assisting Resident #1 for the day notified her that Resident #1 was on the ground, she entered Resident #1's room and observed blood by Resident #1's mouth,		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47065 Based on observations, interviews, and record reviews, the facility failed to ensure that a resident who needs respiratory care is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #2) of 6 residents reviewed for oxygen use and storage. The facility failed to ensure Resident #2's nebulizer mask in her room was stored away when it was not in use on 03/14/25. This deficient practice could place residents at risk of infection. Findings include: Review of Resident #2's Admission Record, dated 03/14/25, reflected an [AGE] year old female who was readmitted to the facility on [DATE]. Resident #2 had diagnoses including Parkinson's disease with dyskinesia (a movement disorder characterized by involuntary, repetitive, and often jerky movements), chronic obstructive pulmonary disease (a group of lung diseases that cause long-term breathing problems), pneumonitis (an inflammation of the lung tissue) due to inhalation of food and vomit, acute respiratory failure with hypoxia (a condition where the lungs struggle to deliver enough oxygen to the blood), and shortness of breath. Review of Resident #2's Annual MDS, dated [DATE], reflected she had a BIMS score of 14, which indicated she was cognitively intact. Review of Resident #2's Care Plan, dated 01/01/25, reflected she had a diagnosis of aspiration pneumonia and COPD. LPNs and RNs were required to monitor, document, and report for any signs and symptoms of acute respiratory insufficiency and respiratory infection. Review of Resident #2's Order Summary Report, dated 03/14/25, reflected Resident #2 had the following active orders: -Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally every 4 hours as needed for SOB/wheezing ordered and started 12/19/24 -Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally three times a day ordered 12/19/24 and started 12/20/24 -Check O2 sat daily every day shift ordered 05/09/24 and started 05/10/24 -Flutter valve after nebulizer treatments to help clear mucus three times a day ordered and started 01/27/25 Review of Resident #2's MAR Schedule for March 2025 reflected LVN A signed administering the following to Resident #2: (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 1 vial inhale orally on 03/14/25 at 8:00 a.m. -Check O2 sats during day shift on 03/14/25 -Flutter valve after nebulizer treatments to help clear mucus on 03/14/25 at 9:00 a.m. Review of Resident #2's O2 Sats Summary, dated 03/14/25, reflected LVN A took Resident #1's O2 Sat levels on 03/14/25 at 8:18 a.m. and 8:19 a.m. An observation of Resident #2's room on 03/14/25 at 10:33 a.m. found Resident #2 was not in her room. Resident #2's nebulizer mask, dated 03/10/25, was on her dresser next to her bed and not in use. There were several thick, brown spots that had the consistency of vomit in the nebulizer mask around the opening of the nebulizer's medication cup. During an interview on 03/14/25 at 10:38 a.m., the Infection Preventionist stated nurses were responsible for changing residents' nebulizer masks weekly and cleaning and bagging nebulizer masks whenever they were not in use. The Infection Preventionist stated nurses were expected to check oxygen equipment to ensure it was properly stored away every 2 hours. The Infection Preventionist stated she knew it was important to store away nebulizer masks when not in use and said, Because infection control. Residents could develop an infection if the nebulizer masks were not bagged whenever they were not in use. During an interview on 03/14/25 at 11:14 a.m., LVN A stated she was the only nurse assigned to work Resident #2's hallway on 03/14/25. LVN A stated nurses were responsible for storing oxygen equipment away when it was not being used, storing nebulizer masks in bags whenever they were not in use, and changing out oxygen equipment weekly. LVN A stated she was in-serviced on oxygen use and storage by the DON and ADON within the last two weeks. LVN A stated she learned to store nebulizers in a bag whenever they were not in use. LVN A stated she checked on residents' oxygen equipment to ensure it was stored away when not in use throughout her shift and during her rounds, which were every 2-4 hours. LVN A stated she most recently checked on Resident #2 in the morning around 8:30-9:00 a.m. LVN A stated she did not know Resident #2's nebulizer mask was not bagged and believed she forgot to bag it after Resident #2 used it the morning of 03/14/25. LVN A stated she knew it was important to store oxygen equipment away when not in use and said, Because infection control and making sure oxygen equipment was being changed. Nebulizers could grow bacteria and it could cause an infection in the lungs. During an interview on 03/14/25 at 2:11 p.m., LVN B stated nurses were responsible for rinsing, air drying, and bagging residents' nebulizers if they were not in use. LVN B also stated nurses were responsible for changing out residents' nebulizers weekly. LVN B stated she checked on residents' oxygen equipment during O2 sat checks and every 2 hours. LVN B stated she knew it was important to store oxygen equipment away when not in use and said, To not have contamination and cause infection from tubing. Residents could get an infection. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/14/25 at 5:12 p.m., the DON stated nurses were responsible for ensuring residents' oxygen use and storage. The DON stated nurses were responsible for changing oxygen tubing weekly. The DON stated nurses dated and stored residents' nebulizers and nasal cannula in bags when not in use. The DON stated she oversaw to ensure oxygen equipment was stored away when not in use. The DON stated she knew it was important to store oxygen equipment away when not in use and said, Because it could cause an explosion if the smoking policy was not complied with. Infection control. If not complied with, it could cause something to the resident. During an interview on 03/14/25 at 6:25 p.m., the ADM stated nurses were responsible for storing oxygen equipment away. The ADM stated she expected the CNAs to notify the nurses if oxygen equipment was not stored away when not in use. The ADM stated the DON oversaw the nurses to ensure oxygen equipment was stored properly when not in use. The ADM stated she knew it was important to store oxygen equipment away properly when not in use and said, So equipment did not get lost and kept for infection control reasons too. Infection control risk could happen to the resident. Review of the facility's In-Services, from 03/01/25 through 03/16/25, reflected staff were not re-educated on oxygen use and storage policy and procedures. Review of the facility's Oxygen Therapy Administration policy, undated, reflected: Purpose: To provide resident with additional concentration of oxygen to facilitate adequate tissue oxygenation .Procedure (to be performed by a licensed nurse) .9. Check cannula placement and humidifier level frequently .Storage of oxygen tubing when not in use: when oxygen is not in use by the resident, the cannula with tubing is to be stored in a plastic bag and attached to the tank or concentrator. E-cylinder tanks are stored in e-cylinder stand.		