STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676292	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Luling	501 W Austin St Luling, TX 78648

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on observation, interview, and record review, the facility failed to develop a baseline care plan that included instructions needed to provide effective and person-centered care of the resident for one (Resident #1) of three residents reviewed for baseline care plans. 1. The facility failed to ensure Resident #1's elopement risk and interventions were included on his baseline care plan. This failures could place residents at risk of not receiving appropriate interventions to meet their needs. Findings include: Review of Resident #1 face sheet reflected at [AGE] year-old male admitted on [DATE] and discharged on [DATE] with diagnoses of muscle wasting and atrophy (decrease in size and mass of skeletal muscle tissue leading to a loss of strength and function), difficulty in walking, unsteadiness on feet (difficulty with balance and coordination), other lack of coordination, and unspecified dementia (cognitive decline, impacting memory, thinking and problem-solving skills that are severe enough to impact daily functioning). Review of Resident #1 admission MDS dated [DATE] reflected a BIMS 10 which indicated a moderate cognitive impairment. Review of Resident #1's admission elopement risk assessment dated [DATE] reflected Resident #1 had a score of five which indicated Resident #1 was at risk of elopement. Further review reflected care plan interventions to apply were routine monitoring of resident. Review of Resident #1's baseline care plan dated 03/04/2025 reflected resident did not have a history of wandering or elopement and did not include Resident #1's elopement risk as indicated from his admission elopement assessment. Review of provider investigation report dated 04/04/2025 reflected Resident #1 eloped from the facility on 04/03/2025 and was returned by a community member. (continued on next page)

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

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2025 at 12:40 PM, LVN E stated that either the DON, or ADON would have notified her of new interventions or any new interventions would be on the 24 hour report. LVN E stated that she looked at care plans for interventions that should be in place or information about the resident. During an interview on 04/17/2025 at 4:15 PM, LVN A stated the purpose of a care plan was to tell the staff exactly what the resident could do, if they were alert, required assistance, if they were a high risk for elopement or a fall risk. LVN A stated interventions for the mentioned would also be included. LVN A stated the ADON was responsible to update the care plan. During an interview on 04/17/2025 at 4:23 PM, LVN I stated that the care plan was supposed to let staff know how to best care for the resident and best interventions. She stated she expected to find falls and elopement risk along with interventions on the care plan. During an interview on 04/17/2025 at 4:49 PM, ADON stated that she was responsible to update care plans. ADON stated a care plan had anything regarding a resident's care. She stated that a care plan should have falls, skin issues, wounds, code status and anything important. She stated that most of the time she is made aware of the interventions through meetings or if the nurse or aides notified her. ADON stated fall interventions should have been on the care plan and elopement risk with interventions. During an interview on 04/17/2025 at 4:57 PM, the DON stated that the purpose of a care plan was to have patient-centered things that staff were going to do for them while the resident was in the facility. The DON stated she was responsible to initiate the care plan and ADON was responsible for updating when there was a change. The DON stated if residents had falls, there should have been interventions related to falls on the care plan. The DON stated if a resident was a high elopement risk it should also be on the care plan with interventions. During an interview on 04/17/2025 at 5:16 PM, the ADM stated the purpose of a care plan was an individualized plan of care for the resident to include what their needs were. The ADM stated if fall interventions and high elopement risk were applicable to the resident then he expected interventions to be on the care plan. Review of facility policy titled Care Plans, Comprehensive Person-Center with revision date of March 2022 reflected a resident's comprehensive care plan included services for the resident to attain to maintain their highest practicable physical, mental, and psychosocial well-being, reflects currently recognized standards of practice for problem areas and conditions, when possible interventions to address underlying sources of problem areas and not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42600 Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified for two (Resident #2 and Resident #3) of five residents reviewed for care plans. 1. The facility failed to ensure Resident #2's elopement risk and interventions were included on his care plan. 2. The facility failed to ensure Resident #3's fall interventions were included on his care plan. These failures could place residents at risk of not receiving appropriate interventions to meet their needs. Findings include: 1. Review of Resident #2 face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of cerebral infarction (type a stroke where brain tissue dies due to lack of blood and oxygen), muscle weakness, other lack of coordination, unsteadiness on feet (difficulty with balance and coordination), aphasia (loss of ability to understand or express speech), and hemiplegia (complete paralysis on one side of body) and hemiparesis (partial weakness on one side of body) following cerebral infarction (stroke) affecting right dominate side. Review of Resident #2 admission MDS dated [DATE] reflected BIMS score of 4 which reflected severe cognitive impairment. Review of Resident #2 elopement risk assessment dated [DATE] reflected Resident #2 was a high risk for elopement and had statements and/or threats to leave the facility. Review of Resident #2 care plan dated 04/04/2025 reflect no information about Resident #2's high risk for elopement and interventions were not included. Review of Resident #2 MD progress note dated 04/11/2025 reflected Resident #2 was restless with anxiety and walked and moved around constantly, risk of elopement on close observation. Review of QAPI action plan dated 04/04/2025 reflected DON to update all resident elopement assessments and DON/ADON to update all care plans of residents with a score of high risk on elopement assessments with completion date of 04/04/2025. During an interview on 04/16/2025 at 1:04 PM, CNA D stated that there were not any residents who were considered a high elopement risk. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/16/2025 at 1:17 PM, CNA C stated there were not any residents who were a high elopement risk. During an interview on 04/16/2025 at 1:26 PM, MA B stated there were no other residents that were a high risk of elopement. During an interview on 04/16/2025 at 2:00 PM, LVN A stated there were no other residents who were deemed a high risk for elopement. During an interview on 04/16/2025 at 3:02 PM, ADON stated elopement assessments were completed with all residents and there were a couple who were high risk. During an interview on 04/16/2025 at 3:10 PM, DON and Regional Nurse stated that Resident #2 was the only resident deemed a high risk for elopement. 2. Review of Resident #3 reflected a [AGE] year-old man readmitted on [DATE] with diagnoses of need for assistance with personal care (need for assistance with care such as bathing, dressing or eating), dysphagia (difficulty swallowing), unspecified fractures of shaft of right femur (break in main part of the right thigh bone), history of falling, unsteadiness on feet (difficulty with balance and coordination), other lack of coordination. Review of Resident #3 quarterly MDS dated [DATE] reflected BIMS of 10 which indicated moderate cognitive impairment. Review reflected Resident #3 was dependent for most ADLs (bathing, toileting, upper/lower body dressing and personal hygiene). Resident #3 was substantial/maximum assistance (helper does more than half the effort) for toilet, chair/bed-to chair transfers. Review of Resident #3 care plan dated 02/21/2024 reflected Resident #3 was a risk for falls due to history of falls. Review reflected increased staff supervision with intensity based on resident need. Care plan did not include to keep resident's bed in low position or to ensure fall mat was at bedside. Review of Resident #3 physician orders with a start date of 02/21/2024 reflected mat on floor at beside every shift. Review of Resident #3 physician orders with a start date of 04/10/2025 reflected fall mat on floor at bedside every shift for fall precautions. Further review reflected order with a start date of 04/17/2025 for low bed with fall mat while in bed for fall safety every shift. During an interview on 04/17/2025 at 12:40 PM, LVN E stated that either the DON, or ADON would have notified her of new interventions or any new interventions would be on the 24 hour report. LVN E stated that she looked at care plans for interventions that should be in place or information about the resident. LVN E stated she expected to find if a resident required a fall mat and to have their bed in low position. During an interview on 04/17/2025 at 12:46 PM, CNA H stated he believed interventions for falls were on the resident's care plan, but he could also ask the nurse. CNA H stated he believed Resident #3 had a floor mat in his room and his bed should be low to the ground. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/2025 at 4:15 PM, LVN A stated the purpose of a care plan was to tell the staff exactly what the resident could do, if they were alert, required assistance, if they were a high risk for elopement or a fall risk. LVN A stated interventions for the mentioned would also be included. LVN A stated the ADON was responsible to update the care plan. During an interview on 04/17/2025 at 4:23 PM, LVN I stated that the care plan was supposed to let staff know how to best care for the resident and best interventions. She stated she expected to find falls and elopement risk along with interventions on the care plan. During an interview on 04/17/2025 at 4:49 PM, ADON stated that she was responsible to update care plans. ADON stated a care plan had anything regarding a resident's care. She stated that a care plan should have falls, skin issues, wounds, code status and anything important. She stated that most of the time she is made aware of the interventions through meetings or if the nurse or aides notified her. ADON stated fall interventions should have been on the care plan and elopement risk with interventions. During an interview on 04/17/2025 at 4:57 PM, the DON stated that the purpose of a care plan was to have patient-centered things that staff were going to do for them while the resident was in the facility. The DON stated she was responsible to initiate the care plan and ADON was responsible for updating when there was a change. The DON stated if residents had falls, there should have been interventions related to falls on the care plan. The DON stated if a resident was a high elopement risk it should also be on the care plan with interventions. During an interview on 04/17/2025 at 5:16 PM, the ADM stated the purpose of a care plan was an individualized plan of care for the resident to include what their needs were. The ADM stated if fall interventions and high elopement risk were applicable to the resident then he expected interventions to be on the care plan. Review of facility policy titled Falls and Fall Risk, Managing with revision date of March 2018 reflected, based on previous evaluations and current data, the staff with identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize the complications from falling. Review reflected environmental fall risk factors included incorrect bed height or width. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor (s) of falls for each resident at risk or with a history of falls. Review of facility policy titled Care Plans, Comprehensive Person-Center with revision date of March 2022 reflected a resident's comprehensive care plan included services for the resident to attain to maintain their highest practicable physical, mental, and psychosocial well-being, reflects currently recognized standards of practice for problem areas and conditions, when possible interventions to address underlying sources of problem areas and not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 42600 Based on observation, interviews and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 3 (Resident #1, Resident #2, and Resident #3) of 5 residents reviewed for accidents and hazards. A) The facility failed to ensure Resident #1 did not leave the facility without supervision and/or staff knowledge as Resident #1 was returned to the facility by a community member on 04/03/2025. B) The facility failed to ensure staff were educated that Resident #2 was a high elopement risk and implement interventions. C) The facility failed to ensure Resident #3's bed was in a low position with a fall mat in place when he fell on [DATE] and sustained a left hip fracture. A & B) These failures resulted in an Immediate Jeopardy (IJ) situation on 04/16/2025. The IJ template was provided on 04/16/2025 at 4:43 PM. C) This failure resulted in an Immediate Jeopardy (IJ) situation on 05/05/2025. The IJ template was provided on 05/05/2025 at 1:17 PM. While the IJs were removed on (A&B) 04/18/2025, and (C) 05/06/2025 the facility remained out of compliance at a scope of pattern and severity level of not actual due to the need to evaluate corrective systems. These failures could place resident at risk of unsafe elopements, falls, injuries, hospitalization , and/or death. Findings include: A) Review of Resident #1 face sheet reflected at [AGE] year-old male admitted on [DATE] and discharged on [DATE] with diagnoses of muscle wasting and atrophy (decrease in size and mass of skeletal muscle tissue leading to a loss of strength and function), difficulty in walking, unsteadiness on feet (difficulty with balance and coordination), other lack of coordination, and unspecified dementia (cognitive decline, impacting memory, thinking and problem-solving skills that are severe enough to impact daily functioning). Review of Resident #1's admission MDS dated [DATE] reflected a BIMS 10 which indicated a moderate cognitive impairment. Review reflected Resident #1 used a walker as a mobility device. Resident #1 required supervision or touching assistance (helper provides verbal cues, touching or steadying) when Resident #1 walked 10 feet - 150 feet. Review of Resident #1's baseline care plan dated 03/04/2025 reflected resident did not have a history of wandering or elopement. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's admission elopement risk assessment dated [DATE] reflected Resident #1 had a score of five which indicated Resident #1 was at risk of elopement. Further review reflected care plan interventions to apply were routine monitoring of resident. Review of Resident #1's elopement risk assessment dated [DATE] reflected Resident #1 was a high risk for elopement. Review of Resident #1's comprehensive care plan dated 04/04/2025 reflected Resident #1 was a risk for injury related to identified elopement risk and/or exit seeking behavior. Review of map reflected that the gas station was 1.2 miles from the facility and near several businesses and resturants. The residential streets have a speed limit of 30 mph. The highway has a speed limit of 55 mph. During an interview on 04/16/2025 at 1:04 PM, CNA D stated that she worked the shift Resident #1 eloped. CNA D stated her shift was from 6:00 PM to 6:00 AM. CNA D stated Resident #1 went to smoke break at 6:30 PM. CNA D stated when a community member brought Resident #1 back to the facility that was when she found out Resident #1 had been gone. CNA D stated it was around 9:00 PM when Resident #1 was brought back. CNA D stated that Resident #1 was ambulatory, and he usually walked back and forth in the facility or sat in the living room or dining room, but she did not see him on that day (04/03/2025). During an interview on 04/16/2025 at 1:17 PM, CNA C stated he was working when Resident #1 had run off and someone found him at the corner store. CNA C stated he did not remember seeing Resident #1 on his shift. During an interview on 04/16/2025 at 1:26 PM, MA B stated she was already off her shift when Resident #1 returned. MA B stated that apparently the elopement happened right after she left. MA B stated she last saw Resident #1 around 7:30 PM as he was sitting outside with her. MA B stated she was charting and Resident #1 was sitting outside. MA B stated she then clocked out but she stated she did not remember if Resident #1 was sitting outside when she left and stated she was not paying attention. During an interview on 04/16/2025 at 1:37 PM, the DOR stated that Resident #1 was on physical therapy prior to his elopement. The DOR stated that Resident #1 was slow when he walked with a walker. The DOR stated Resident #1 had balance issues and that was the reason he was on service with physical therapy. The DOR stated Resident #1's last therapy progress note reflected he was slow and took a while to walk 150 feet in the facility. During an interview on 04/16/2025 at 2:00 PM, LVN A stated that her shift started at 2:00 PM on 04/03/2025 and dinner was 5:00 PM. LVN A stated that smoke break was at 6:30 PM and she last saw Resident #1 sitting in the living room at 6:30 PM in the living room watching television. LVN A stated that aides went on break around 7:30 PM. LVN A stated Resident #1 returned to the facility around 9:20 PM - 9:30 PM. LVN A stated that the community member stated they had worked in the facility earlier in the day as a contractor and recognized Resident #1 when he drove by the gas station. LVN A stated that resident had a slow walk with his walker, but felt he was stable when he walked. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/16/2025 at 3:02 PM, the ADON stated she did not know how long Resident #1 was gone because it was not reported to her. The ADON stated Resident #1 was returned to the facility by a community member. The ADON stated that CNAs completed rounds every two hours and nurses should complete rounds every hour or two and this included putting an eye on residents to just check on them. During an interview on 04/16/2025 at 3:10 PM, the ADM stated that Resident #1 was returned to the facility around 9:45 PM or 9:50 PM on 04/03/2025. The ADM stated a few staff members were outside at 7:30 PM and took a break and came in and that was the last time ADM was aware any staff saw Resident #1. The ADM stated aides should round on residents every two hours and nurses should have rounded on the off hour. The ADM stated he expected the nurse to be aware of where residents were as best as possible due to the population of the facility. B) Review of Resident #2 face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of cerebral infarction (type a stroke where brain tissue dies due to lack of blood and oxygen), muscle weakness, other lack of coordination, unsteadiness on feet (difficulty with balance and coordination), aphasia (loss of ability to understand or express speech), and hemiplegia (complete paralysis on one side of body) and hemiparesis (partial weakness on one side of body) following cerebral infarction (stroke) affecting right dominate side. Review of Resident #2 admission MDS dated [DATE] reflected BIMS score of 4 which reflected severe cognitive impairment. Review of Resident #2 elopement risk assessment dated [DATE] reflected Resident #2 was a high risk for elopement and had statements and/or threats to leave the facility. Review of Resident #2 care plan dated 04/04/2025 reflect no information about Resident #2's high risk for elopement and interventions were not included. Review of Resident #2 MD progress note dated 04/11/2025 reflected Resident #2 was restless with anxiety and walked and moved around constantly, risk of elopement on close observation. During an interview on 04/16/2025 at 1:04 PM, CNA D stated that there were not any residents who were considered a high elopement risk. During an interview on 04/16/2025 at 1:17 PM, CNA C stated there were not any residents who were a high elopement risk. During an interview on 04/16/2025 at 1:26 PM, MA B stated there were no other residents that were a high risk of elopement. During an interview on 04/16/2025 at 2:00 PM, LVN A stated there were no other residents who were deemed a high risk for elopement. During an interview on 04/16/2025 at 3:02 PM, ADON stated elopement assessments were completed with all residents and there were a couple who were high risk. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/16/2025 at 3:10 PM, DON and Regional Nurse stated that Resident #2 was the only resident deemed a high risk for elopement. Review of provider investigation report dated 04/04/2025 included statement from LVN A which reflected on 04/03/2025 a community member brought Resident #1 to the nurses station. Resident #1 had his walker and had grass and mud on his pants and shoes. LVN A wrote that Resident #1 was by the gas station down the street from the facility. LVN A's statement reflected that the community member recognized him from the facility. LVN A's statement reflected Resident #1 had a head-to-toe assessment and no injuries were found. Review reflected elopement assessments were conducted with all residents and care plans were to be updated if residents were found a high risk for elopement. In-service dated 04/04/2025 conducted with all staff, reflected all residents wanting to go out on pass and leave the facility needed MD approval, RP approval and any legal entity approval. Residents also needed to sign out with the nurse in the sign-out book and provide who was taking the resident out, the resident's name, where they were going, time they left, when they would return, a phone number and information that failure to comply would result in the facility finding alternative placement. In-service dated 04/03/2025 reflected in-service was completed with staff on wandering and elopement. Review of facility policy with revision dated 2001 and titled Wandering and Elopements' reflected the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Review reflected if resident was identified as risk for elopement care plan will include strategies to maintain safety. C) Review of Resident #3 reflected a [AGE] year-old man readmitted on [DATE] with diagnoses of need for assistance with personal care (need for assistance with care such as bathing, dressing or eating), dysphagia (difficulty swallowing), unspecified fractures of shaft of right femur (break in main part of the right thigh bone), history of falling, unsteadiness on feet (difficulty with balance and coordination), other lack of coordination. Review of Resident #3 quarterly MDS dated [DATE] reflected BIMS of 10 which indicated moderate cognitive impairment. Review reflected Resident #3 was dependent for most ADLs (bathing, toileting, upper/lower body dressing and personal hygiene). Resident #3 was substantial/maximum assistance (helper does more than half the effort) for toilet, chair/bed-to chair transfers. Review of Resident #3 care plan dated 02/21/2024 reflected Resident #3 was a risk for falls due to history of falls. Review reflected increased staff supervision with intensity based on resident need. Care plan did not include to keep resident's bed in low position or to ensure fall mat was at bedside. Review of Resident #3 physician orders in Matrix with a start date of 02/21/2024 reflected mat on floor at beside every shift with no discontinue date. Review of Resident #3 physician orders in PCC with a start date of 04/10/2025 reflected fall mat on floor at bedside every shift for fall precautions. Further review reflected order with a start date of 04/17/2025 for low bed with fall mat while in bed for fall safety every shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of incident report dated 04/02/2025 completed by LVN E, reflected CNA called LVN E to Resident #3's room. Resident #3 was noted on floor near door with wheelchair at side without complaints of pain. Further review reflected bed not in low position and fall mat not on floor. Review of admission summary dated 04/04/2025 reflected Resident had diagnoses of intertrochanteric fracture left femur (left hip fracture). Review of Resident #3's discharge information dated 04/04/2025 reflected resident had a hip fracture treated with ORIF (where pieces of fractured bones are surgically aligned and held in place with implants like screws, plates or rods). Observation 04/17/2025 at 10:26 AM, revealed CNA G lowered Resident #3's bed to the lowest position via manual crank at the foot of the bed, under the footboard. Observation revealed control Resident #3 had access to adjust the head and foot of the bed and Resident #3 would have been unable to raise the height of the bed on his own. During an interview on 04/17/2025 at 10:12 AM, LVN E stated that she was on shift the morning of Resident #3's fall. She stated she received a call from a CNA that Resident #3 had fallen. She stated she believed the CNA was CNA F that called her. LVN E stated that Resident #3 was on his left hip and tried to move himself. LVN E stated CNA F called her between 6:00 AM and 6:15 AM and she had not yet done her morning rounds as she was counting medications. LVN E stated interventions to prevent falls for Resident #3 were to have his bed in low position and a fall mat at bedside. LVN E stated that Resident #3's bed was not in low position, and he did not have fall mat. LVN E described the height of the bed as where an aide would have raised it to change a resident. LVN E stated that Resident #3 had no complaints of pain, but due to the height of the bed, his age and prior fall she suggested sending him out to the ER and MD agreed. During an interview on 04/17/2025 at 10:19 AM, CNA F stated she had just started her shift at 6:00 AM and heard Resident #3 yelled out. CNA F stated she saw Resident #3 on the floor and she called for the nurse. CNA F stated Resident #3 would raise his bed up and down on his own. CNA F stated she did not see a floor mat in his room that day. CNA F stated she did not usually work with CNA F but went to assist because she heard him yell. During an interview on 04/17/2025 at 10:26 AM, CNA G stated she usually worked with Resident #3. She stated his fall interventions included to put a mat on the floor and to have his bed in the lowest position. CNA G stated Resident #3 raised his own bed and had a control to raise it. CNA G stated she did not think Resident #3 had a bed that lowered all the way to the ground. (continued on next page)

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	676292	A. Building B. Wing	05/06/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 04/17/2025 at 11:45 AM, the DON stated Resident #3 was found on the floor at shift change. The DON stated that Resident #3 was sent to the ER for evaluation and stated he should have a low bed and fall as those were interventions prior to the fall on 04/02/2025. The DON stated it was discussed with the nurse that Resident #3 was a fall risk and to have his bed in a low position and fall mat in place because of his history of falls. The DON stated it was discussed verbally with the nurses and CNAs. The DON stated that the facility is going through a change in HER systems. She stated that with the old system she would have looked at the incident report for Resident #3. The DON stated with the new system it looked like she and the ADM reviewed it. The DON stated that she wanted to discuss with MD if Resident #3 had osteopenia because the level he fell from should not have resulted in a hip fracture. The DON stated it was reported to her that Resident #3's bed was in a low position, but she did not recall who reported that to her. The DON stated she did not review the incident report and stated I did not know how to. The DON stated she was not aware the incident report reflected that Resident #3's bed was not in a low position and that he did not have a fall mat in place at the time of his fall. A phone interview was attempted with the MD on 04/16/2025 at 4:13 PM and 04/17/2025 at 12:06 PM, but the phone call was not returned. During an interview on 05/05/2025 at 2:58 PM, CNA F stated that Resident #3 was near the door and stated that he screamed and that his wheelchair was tipped over on the floor. CNA F stated Resident #3 had fallen out of bed and it looked like he crawled to the door in his room. CNA F stated that Resident #3 was usually helped up by the 6:00 AM - 2:00 PM shift and he was not up when she got to the facility at 6:00 AM for her shift. During an interview on 05/05/2025 at 2:59 PM, LVN E stated that when CNA F called her to Resident #3's room he was near his doorway with his hands maybe a foot from his doorway. CNA F stated that the 6:00 am - 2:00 pm shift got Resident #3 up for the day. LVN E stated that it looked that Resident #3 had crawled from where his bed way. LVN E stated it was obvious based Resident #3 crawled and fell out of bed. LVN E stated Resident #3 head was toward the door of the room and he leaned on his right side. LVN E stated that Resident #3's was folded up and on it's side tipped over. Review of facility policy titled Falls and Fall Risk, Managing with revision date of March 2018 reflected, based on previous evaluations and current data, the staff with identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize the complications from falling. Review reflected environmental fall risk factors included incorrect bed height or width. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor (s) of falls for each resident at risk or with a history of falls. Review of facility policy with revision date of July 2017 and titled Safety and Supervision of Residents reflected our facility strives to make the environment free from accident hazards as possible. Resident safety and supervisions and assistance to prevent accidents are facility-wide priorities. Review reflected interventions to reduce accident risks and hazards included ensuring interventions were implemented and documenting interventions. A&B) The ADM, ADON and regional nurse were notified on 04/16/2025 at 4:54 PM, that an IJ had been identified. An IJ template was provided, and a POR was requested. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	C)The ADM, and regional nurse were notified on 05/05/2025 at 1:17 PM, than an IJ had been identified. An IJ template was provided, and a POR was requested. A&B) The following POR was approved on 04/18/2025 at 9:59 AM and indicated: [Facility] IJ Plan of Removal F689 4/16/25 Resident #1 was discharged to a secured facility on 4/8/25. All entrances to the facility have been key- pad locked as of 4/4/25 and residents are not allowed out of the facility without an assigned staff member being with them. There is currently one (1) resident who is high risk for elopement and on 4/16/25 at 5:30 PM he was placed on 1:1 monitoring until secure placement is located for him. The facility has sent information to three (3) other facilities and placement has not yet been secured. On 4/4/25, all resident elopement assessments were completed, and one (1) resident was identified as high risk as identified below. On 4/16/25, the identified high risk residents care plan was formulated. Any resident care plans requiring updates was done at this time. On 4/16/25, the administrator in-serviced department heads and100% of facility staff were in-serviced on interventions for the identified high risk resident including 1:1 monitoring, updated care plan indicating 1:1, and Kardex update so that CNAs can be alerted. Also included in this in-service was notifying the administrator of any resident exhibiting high risk behavior or scoring high risk (score over 10) on an elopement assessment so that interventions can be identified and staff informed. Staff not available in person were contacted by phone and verbally in-serviced. Staff are informed that the administrator/designee will notify staff through the above measures and through an in-service if any other resident is deemed high risk for elopement. PRN, agency staff, and new hires will be educated on this process as they are assigned to work by the administrator, DON, or an administrative staff member. Initial comprehension of understanding was done by the administrator on 4/17/25, by questioning staff regarding training. The administrator/designee will interview staff two times (2) a week for one (1) month on their understanding and retention of education given to them on elopement and where to find information on residents at high risk for elopement. The Regional Nurse will monitor new admission elopement assessments for high risk residents, weekly, for one month and randomly thereafter to validate that interventions are in place and communication is in the EMR system. The administrator will document this on an audit form. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/16/25, the regional nurse in-serviced the administrator and the director of nursing on reviewing any new admission elopement assessments within twenty-four hours of admission to identify a resident scoring ten (10) or more. Included in this in-service is ensuring that any new staff are educated to the interventions of a resident deemed high-risk for elopement. Initial comprehension of education with the administrator and the DON was completed on 4/17/25, with questioning on understanding of the training by the regional nurse consultant. The regional nurse will document compliance using an audit form. On 4/16/25 at 6:00 PM a Ad.Hoc QAPI meeting was completed with the IDT and the medical director to discuss this plan of removal. C)The follow POR was approved on 05/06/2025 at 3:15 PM and indicated the following: IJ Plan of Removal F689 5/5/25 On 5/5/25, an abbreviated survey was re-opened at facility. On 5/5/25, the surveyor provided an immediate jeopardy (IJ) template notification that the regulatory services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure Resident #1s bed was in the lowest position and had fall mat in place when he fell on [DATE] and fractured his left hip. Resident #1s fall care plan interventions and Point of Care Kardex were reviewed and updated to reflect the resident's current condition. On 5/5/25, the Regional Nurse Consultant/ADON, reviewed the facility fall assessment report to identify residents at risk of falls and to validate that current interventions are in place on the resident care plan and Point of Care Kardex. The RNC and the ADON reviewed all facility residents to validate that their fall interventions were care planned and that the Point of Care Kardex was updated to list the fall interventions. This audit was documented utilizing the PCC Fall Assessment score report. Twelve (12) additional residents were identified as at risk for falls. Each had a care plan developed with interventions added to their POC Kardex. On 5/5/25, the RNC/administrator educated 100% of facility staff regarding where to find the information for fall interventions. Staff not receiving the initial education will receive if before starting their next assigned shift. Nurses were instructed to review the care plan, and CNAs were instructed to review the Point of Care Kardex. 100% of the interdisciplinary team (IDT) were given a list of resident fall interventions by the RNC, to refer to while making rounds on their regularly assigned residents before the morning stand-up meeting and reporting any concerns during that meeting. The IDT manager on duty will make rounds on the weekend to identify and immediately resolve concerns with fall interventions. The administrator verified the initial Comprehension of staff training by questioning staff and documenting it on an audit form. The administrator and the RNC will document these tasks on a facility created audit form for record keeping purposes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews conducted between 04/17/2025 and 04/18/2025, 4 LVNs, 4 CNAs, 1 HSK ADON, DON, ADM and regional nurse, revealed that Resident #2 is the only resident currently a high risk for elopement and he currently is on 1:1. Staff interviewed stated they can determine who was a high elopement risk by looking at the resident's Kardex or in PCC. Nurses interviewed stated that any resident who scored a 10 or high and was deemed a high elopement risk on the elopement assessment would notified the DON and ADM immediately. Staff stated that any changes in behavior or increase in wandering should be notified to the charge nurse and then the DON and ADM immediately. During interviews conducted on 04/18/2025, regional nurse, DON and ADM stated that any new admission will be reviewed by regional nurse within 24 hours. They stated nurses have been in-serviced to notify the DON and ADM immediately of any residents who scored high-risk for elopement. The care plan should also be updated and this included their baseline care plan. Resident #2 was currently 1:1. They stated education will be on going and staff will be tested for retention. C)Monitoring for POR occurred on 05/06/2025 as followed: Review of 12 residents identified as at risk for falls indicated fall evaluation was completed and care plans included that the residents were a fall risk and interventions for each resident. Review of in-service sign-in sheet dated 05/05/2025 at 05/06/2025 reflected subject of fall interventions completed with staff on shift and prior to the start of their next shift. Information reviewed included staff is to ensure residents are safe by ensuring their fall interventions are always in place. Nurses can find residents fall interventions on their care plan as well as the resident Kardex in PCC. CNAs can find fall interventions on the resident point of care Kardex in PCC. Staff should round at the start of their shift and at least every two hours to ensure listed fall interventions are in place. In-service included list of residents who had interventions in place such as a low bed or fall mat. Review of initial comprehension questionnaire dated 05/05/2025 and 05/06/2025 reflected ADM tested comprehension of POR information reviewed with nurses, aides and IDT. Review of QAPI meeting dated 05/05/2025 reflected IDT members and medical director attended. Review of in-service sign-in sheet dated 05/05/2025 reflected subject of fall interventions and rounds completed with IDT reflected IDT should round prior to the morning meeting to assigned ground of rooms and weekends when assigned as weekend manager. Rounds include fall hazards in the resident room, medications at bedside, water or fluid on the floor, anything left out that can be a hazard, fall interventions and to notify nursing management / administrator if interventions are not in place. During interviews on 05/05/2025 with IDT members, BOM, HR, AD, maintenance director and DOR reflected they were provided a list of residents who had fall interventions in place and were responsible to round prior to morning meeting during the week and on weekends when assigned weekend manager. IDT members stated that they can also find fall interventions in the residents care plans. IDT members stated that if interventions were not in place and it was something they could fix they would fix it, but if not they would notify the nurse, ADM or DON. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 05/06/2025 with 2 CNAs, 2 LVNs, and 1 cook reflected they received an in-service on fall interventions on 05/05/2025 or 05/06/2025 provided by the ADM. Staff stated that they can find fall interventions on the Kardex in PCC or in the resident's care plan. They stated they should round at least every two hours and at the beginning and end of their shift and look that fall interventions are in place. Staff stated they can fix interventions they see out of place and if they see something that could cause harm they would notify the ADON or ADM. During an interview on 05/06/2025 at 3:49 PM, regional nurse stated that ADM would in-service any agency or new hire staff prior to working their first shift on falls and interventions. Regional nurse stated that when fall interventions are put in place, the Kardex and care plan would be updated and an updated IDT list would be provided by the ADM and discussed during morning meeting. She stated staff will have comprehension completed two times a week for a month. Regional nurse stated that falls would be reviewed during daily IDT and discussed and regional nurse until a DON is hired. Regional nurse stated if an issue were found during a fall audit depending on the issue, remedy could include re-educate, if incident report had issue nurse would be reeducated if care plan didn't have interventions MDS nurse would be educated. During an interview on 05/06/2025 4:04 PM, ADM stated that agency or new staff would be informed of residents who were at risk for falls by ongoing fall prevention in-service being included on the 24-hour report to catch any new or agency staff. ADM stated staff would be informed of update during morning h [TRUNCATED]

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42600 Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 8 of (03/15/2025, 03/16/2025, 03/22/2025, 03/23/2025, 03/29/2025, 03/30/2025, 04/11/2025, and 04/12/2025) 33 days reviewed for RN coverage. The facility failed to ensure they had an RN charge nurse on 03/15/2025, 03/16/2025, 03/22/2025, 03/23/2025, 03/29/2025, 03/30/2025, 04/11/2025, and 04/12/2025. This failure could place residents a risk of missed nursing assessments, interventions, care and treatment. Findings included: Review of daily sign-in schedule for March 15, 2025 through April 17, 2025, reflected zero hours work by an RN charge nurse on the following days: 03/15/2025, 03/16/2025, 03/22/2025, 03/23/2025, 03/29/2025, 03/30/2025, 04/11/2025, and 04/12/2025. During an interview on 04/17/2025 at 3:20 PM, the ADON reflected that between 03/15/2025 and 04/17/2025 there was not an RN that worked at the facility on the weekends. The ADON stated between that time, an agency RN worked on 04/05/2025 and the DON was at the facility on 04/05/2025 and 04/06/2025. During an interview on 04/17/2025 at 4:49 PM, the ADON stated that she was responsible for MDS, transportation, staffing/scheduling and worked as an ADON. The ADON stated that the facility had no circumstances that required an RN onsite. The ADON stated if the facility did, they would reach out to regional nurse and DON as they lived close by. The ADON stated she did not know what the protocol was when the facility did not have an RN available to work the required 8 consecutive hours a day. The ADON stated the facility did not get residents who were a high acuity, so the facility did not have residents that required services provided by an RN. During an interview on 04/17/2025 at 4:57 PM, the DON stated that the facility had no had any care come up that required an RN. The DON stated she would have handled it if something came up that required RN intervention. The DON stated that she brought up to management that the facility needed an RN for weeks and stated the facility tried to actively hire an RN for coverage on the weekends. The DON stated she was at the facility Monday through Friday from at least 8:00 am to 5:00 pm and usually longer. During an interview on 04/17/2025 at 5:16 PM, the ADM stated the facility did not take on any resident who required 24 hour RN care. The ADM stated if there was items that needed to be completed by an RN the DON or regional nurse would come in or the DON from a nearby sister facility. The ADM stated that the facility had an ongoing job posting on several platforms. The ADM stated that he tried to employee an RN for years but because of the rural area it made it difficult. The ADM stated the facility did not have a weekend RN that came into work. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/17/2025 at 5:17 PM, regional nurse stated the facility did not have a specific policy regarding RN coverage and that the facility followed state guidelines.