STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676300	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Oaks	1901 S Trade Days Blvd Canton, TX 75103

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 - 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** 19401 Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 2 of 7 resident (Resident #1 and Resident #2) reviewed for accidents and supervision. 1. The facility failed to ensure CNA A appropriately transferred Resident #1 who was identified as a two person assist for bed mobility. Resident #1 was assisted by CNA A for ADL care on [DATE]. CNA A rolled Resident #1 over in the bed, he fell and broke both hips. 2. The facility failed to ensure Resident #2, who could not bear weight and was identified as a Hoyer lift transfer, was transferred using a Hoyer lift. CNA C transferred Resident #2 using a stand and pivot transfer on [DATE]. Two days later an x ray report indicated the resident had a fractured hip. There was no other occurrence identified that could have caused the injury. The noncompliance was identified as PNC. The IJ began on [DATE] and ended [DATE]. The facility had corrected the noncompliance before the survey began. These failures could place residents at risk of serious harm, pain and serious injury. Findings include: 1. Record review of Resident #1's face sheet indicated a [AGE] year-old male who was last admitted to the facility on [DATE]. Resident #1 had diagnoses which included limitation of activities due to disability, abnormalities of gait and mobility, unspecified lack of coordination, a loss of bone density and muscle weakness. Record review of Resident #1's census report indicated his initial date of admission to the facility was [DATE]. Record review of Resident #1's Quarterly MDS, dated [DATE], indicated he had intact cognition with a BIMS(a score used to assess cognitive function in long term care settings) score of 14. Resident #1 was totally dependent of staff for toileting and hygiene. He was totally dependent of staff requiring the assist of two or more helpers for siting to laying and lying to sitting on the side of the bed. (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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(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	Record review of Resident #1 care plan with a problem of falls related to mobility. Approaches, dated [DATE], were to provide extensive assistance for transferring via a Hoyer lift. Resident #1 was identified with a problem of incontinence of bowel and bladder. An approach, dated [DATE], indicated to provide extensive assistance for toileting. A Problem start date of [DATE] indicated the resident fell /slid from his bed with fractures. Some of the interventions were to re-educate the resident was a two person assist with bed mobility, and peri care to help reduce the risk of falls/slides. The bed was to be in the lowest position. Record review of Resident #1's Resident Profile (a description of resident needs for aides to follow when providing care according to the DON) indicated his ADL status, dated [DATE], for toileting required the assistance of two people and his bed mobility was listed as extensive with the assistance of two people. Resident #1's transfer assistance indicated two people assist via Hoyer lift. Record review of Resident #1's nursing note, dated [DATE] at 10:19 p.m., indicated LVN B as called to Resident #1's room around 7:20 p.m. CNA A aid she was changing Resident #1 and he slid out of the bed while she had him roll unto his side. Resident #1 was yelling his hips were hurting. The resident was assessed. Two additional aides came in to assist with cleaning feces off the floor and covered the resident with a blanket. The staff were instructed not to move the resident and 911 was called. The resident was given fentanyl via nasal inhalation by EMS to relieve some pain so the resident could be moved to have the Hoyer sling placed under him. The resident left the facility with EMS at 7:42 p.m. The hospital was contacted at 10:20 p.m. and they stated Resident #1 had fractures in each hip. Record review of the facility's Provider Investigation Report indicated the incident occurred on [DATE] at 8:00 p.m. CNA A provided ADL care to Resident #1 alone and fell out of bed. Resident #1 was care planned for a two person assist. The nurse assessed Resident #1 and he was sent to the ER. The hospital called later in the evening to say Resident #1 suffered fractures to the right and left hips. Resident #1 was care planned for a two person assist for quite some time. All staff interviewed on the hall reported being aware of this and always ensured they had assistance when changing Resident #1. CNA A stated she provided care to Resident #1 in the past without assistance. She was aware of how to use the POC kiosk and where to find Resident #1's care plan. CNA A willfully chose to ignore the plan of care and make and independent decision to provide incontinent care to Resident #1 by herself and paced the resident at needless risk resulting in a fall. Record review of Resident #1's hospital records, dated [DATE], indicated he had a fall from his bed at the nursing home. His imaging demonstrated he sustained multiple orthopedic injuries which included right and left hip fractures. Review of the CT (imaging that uses x rays and computer technology to create detailed images of the inside of the body) of the pelvis on [DATE] at 11:24 p.m. indicated acute comminuted (fracture where bone breaks in three or more fragments) fracture of the left and right hips. Record review of Resident #1's computerized physician orders indicated he had an order, dated [DATE], for Tramadol 50mg every six hours PRN for bone density and structure disorders. He had an order dated [DATE] for alprazolam 0.25 mg for anxiety at bedtime and PRN. He had an order, dated [DATE], for hydrocodone/acetaminophen ,d+[DATE] 1 table for fracture, every 6 hours PRN. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review CNA A's statement taken by the HR director on [DATE] at 12:00 p.m. indicated CNA A said she was scheduled to work until 7:00 p.m. on [DATE]. The statement indicated CNA A said around 7:30 p.m. she went into Resident #1's room to change him like she always changed him, and during the process she realized the whole bed was wet. She said she was standing on the far side of the bed next to the window. Resident #1 used the grab bar to turn away from her and hold on. CNA A said Resident #1 had neuropathy in his hands and feet. As she was changing him, she guessed his hand became weak. She saw his feet fall off the bed. She said Resident #1 fell off the other side of the bed, he started to yell that he was falling. CNA A said she was reaching for him to prevent his fall and hurt her back. She said he fell feet first onto the floor. She said she was yelling, and he was yelling, and the other CNA came into the room after he was already on the floor. Record review of a statement written by LVN B indicated on [DATE] when she entered the room Resident #1 was lying on the floor next to his bed that was in the high position. Resident #1's head was positioned towards the foot of the bed. Resident #1 was yelling it hurts, it hurts. The statement indicated 911 was called. Record review of Resident #1's nursing note, dated [DATE] at 2:02 a.m., indicated the resident was back from the hospital. He had a diagnosis of bilateral subtrochanteric femur fractures. PRN Tramadol 5mg was given. The medication was not effective. The resident was yelling out in pain. When asked if he would like to go back to the ER for further evaluation the resident refused. The nurse and aide tried to reposition the resident. The resident was unable to get comfortable. Record review of Resident #1's nursing notes, dated [DATE] at 11:24 a.m., indicated the resident was sent back to the hospital due to symptoms of severe anemia(lack of blood). Record review of Resident #1's nursing note, dated [DATE] at 2:55 p.m., indicated Resident returned from the hospital with a new order for alprazolam 0.25 mg as needed for sleep. Record review of Resident #1's nursing note, dated [DATE] at 12:55 a.m., indicated Resident #1 complained of discomfort when changed or repositioned. PRN pain medications were given. Record review of nursing note, dated [DATE] at 11:01 a.m., indicated new order to change hydrocodone /acetaminophen ,d+[DATE] every 6 hours routine medication. Record review of a nurse's note, dated [DATE] at11:23 a.m. indicated a new order to change to discontinue alprazolam 0.25 PRN and to start lorazepam 0.5 tablet for anxiety. Record a review of a nurses note, dated [DATE] at 2:59 p.m., indicated Resident #1 had 3 plus edemas noted. He complained of pain in the left ankle and foot. The physician was notified, and a new order was received to send him to the ER. Record review of Resident #1's nurses note, dated [DATE] at 2:05 p.m., indicated and a referral was received for hospice related to uncontrollable pain with symptoms of bilateral hip fracture and recent decline. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of a nurse's note, dated [DATE] at 2:13 a.m., indicated Resident #1 was admitted to hospice with a terminal diagnosis of systolic congestive heart failure (Heart failure where the left ventricle cannot pump blood efficiently) he had new orders for morphine 0.5 ml every two hours PRN as needed for pain, lorazepam 0.5 mg tablet take one every four hours PRN for anxiety. To discontinue the hydrocodone and began Hydrocodone acetaminophen ,d+[DATE] every 6 hours PRN. Acetaminophen 650 mg to administer one suppository rectally every 4 hours PRN for pain or temperature. During an interview on [DATE] at 1:50 p.m., the DON said Resident #1 was a 2 person assist with ADL care. She said it clearly stated in his plan of care documentation. She said Resident #1 did not have the ability to grip and hold on to the handrail on the bed. The DON said she was confused by CNA A's behaviors that day, CNA A's shift ended at 7:00 p.m. The DON said the other aides on the hall thought she already left for the day, instead she was in the room providing care to Resident #1 at about 7:30 p.m. She said CNA A was suspended and terminated, she did not work again after the incident. The DON said the fall caused Resident #1 to break both femurs. The DON said when the aide was providing care to him, she had the bed in the highest position when she rolled him. She said according to the aide and the resident interviews his legs fell off the side of the bed and he followed. The DON said Resident #1's legs hit the floor first. She said CNA A worked at the facility for 6 or 8 months, and the aides rotated different halls. The DON said that was not her first time working with Resident #1. During an interview on [DATE] at 2:20 p.m., Resident #1 said he remembered the incident when CNA A was in changing him and he rolled out of bed. He said she changed him in the past unassisted and he had no worries at first. He said the other staff always had two people to assist him. Resident #1 said she was by the window, and he was facing the door. He said his feet just slipped off the bed. He said he was in shock when he felt the rest of his body began to follow. He said he had been in pain ever since the fall. Resident #1 said since that time it was always two staff who provided care to him and he was fine. Resident #1 said the facility changed his pain medications, the pain was better, but he just felt like he would always be in pain. During an interview on [DATE] at 3:09 p.m., the Administrator said Resident #1 said CNA A changed him alone before. The Administrator said Resident #1 said CNA A was the only one who provided him care unassisted. During an interview on [DATE] at 3:26 p.m., the DON said the facility's Mitigation plan for Resident #1 was completed immediately. The DON said agency staff were in serviced as they came into work. She said in services began on [DATE] and were still on going for Agency and PRN staff. She said the staff were in-serviced on instructions for how to enter the plan of care information for the resident's profile. The DON said the resident profile was used by the CNAs to determine the level of care to provide to residents. She said in Mitigation plan they went back 2 weeks and monitored for trends and there were not any problems identified. She said they talked about accidents/incidents in morning meeting and made sure nothing was identified. The DON said each day she looked at the schedule to determine if they had new staff or staff that had not been in serviced. She said CNA A knew how to get in the Kiosk and she knew where the pocket worksheets were. The DON said there was a binder on the hall by the Kiosk with the resident profiles in it. She said the Mitigation plan included in services for aides and nurses. She said the aides had to do a return demonstration on the kiosk to show they knew how to use it correctly. (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 [DATE] at 1:50 p.m., the DON said Resident # 1 was a 2 person assist with ADL care. She said it clearly stated in his plan of care documentation and everywhere. She said Resident #1 did not have ability to grip and hold onto the bars on the side of the bed. The DON said she was confused by CNA A's behaviors that day, she was supposed to have gotten off work at 7:00 p.m., she said the other aides on hall thought she had already left for the day. She said she was in Resident #1's room around 7:30 p.m. providing care to him. The DON said the fall caused Resident to break both femurs. The DON said when the aide was providing care to him, she had the bed in the highest position when she rolled him. She said according to the aide and the resident interviews his feet fell off the side of the bed and his legs followed. She said CNA was terminated- and did not work again. He went over the side of the bed, so his legs hit first. She had worked at the facility for about 6 months, and didn't know if she worked that hall. Record review of CNA A's personnel file indicated a hire date of [DATE] and a CNA Competency check list which indicated competency on Resident Profile and care delivery. Record review of an in service, dated [DATE], on transfers indicated to check the profile of each resident prior to transfers to prevent injuries. Ask for help if a resident seems more confused than usual. Use a Hoyer for residents that list it on the profile under ADLS. The in service also included instructions for the Kiosk, instructions on selecting the resident profile for the most recent accurate care plan. CNA A signed the in service which indicated she had attended. Record review of CNA A's Suspension Pending Investigation form, dated [DATE], indicated the employee was changing Resident #1, and he fell out the bed which resulted in him going to the ER. The Employee said it was an accident, she did not mean for the resident to get hurt. The employee stated she injured herself trying to catch the resident. The form indicated she was too upset to sign the form. Record review of a Termination Form, with an effective date [DATE], indicated CNA A's last day to work was [DATE]. She was terminated due to a violation of rules and policy. Record review of the Mitigation Plan, dated [DATE], indicated the concern was a fall out of bed with major injury. The incident was reported to HHSC, an investigation was initiated, and the staff member was immediately suspended pending investigation, sent home and removed from the schedule on [DATE]. Residents who required assistance with bed mobility have the potential to be affected. The current Residents were assessed by the DON/designated for appropriate amount of ADL assistance assigned to each resident for bed mobility, toileting, and to validate amount of assistance displayed in the resident profile. This was completed on [DATE]. Current residents with incident/accident reports for the past 14 days were reviewed by the DON and or designated to determine the root cause analysis of the fall, and validate that interventions were implemented as appropriate for root cause analysis. Daily review of incident/accidents in the daily clinical meeting Monday through Friday will be completed by [DATE] and ongoing Monday through Friday. Licensed nurses were re-educated on completing resident profiles upon admission and updating with any changes so that the profiles remained accurate with needed information to reflect the resident. The plan of care included the amount of assistance needed with ADLs and identified resident risks. CNAs were re-educated on following the designated amount of ADL assistance care plan in the resident profile. CNAs were educated on positioning with skills check off that was completed on [DATE]. Staff were educated on abuse, neglect, and exploitation completed on [DATE]. The facility administrator was responsible for the overall implementation of validation of this plan and the facility director was informed of this plan. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility Provider Investigation Report, dated [DATE], indicated the Provider Action Taken Post-Investigation was conducted as needed QAPI with root cause analysis. A Mitigation plan was initiated to include but not limited to identifying all residents who had the potential to be harmed by this alleged deficient practice, residents were reassessed for accuracy. Licensed nurses were re-educated on completing resident profiles on admission. CNAs were educated on following designated amount of assistance and position with skills check offs completed. Record review of the facility's mediation plan indicated they conducted an in-service on abuse neglect the exportation on [DATE] for agency and facility staff. Record review of an in-service, dated [DATE], indicated nurses were in-service on point of care profile for residents. The in-service indicated to always use the care plan/resident profile to make determinations such as the number of staff, the extent of moderate, or minimum needed to give care. It indicated to never use less than what was listed in the plan of care. There were also directions on how to sign into the POC and it gave pictures with an example of navigating the system. Record review of the staff education/orientation on policies and procedures indicated the staff demonstrated competency in moving positioning and assisting residents. It appeared that all aides had competency check offs. Record review of the facility's plan of care/resident profiles indicated all resident profiles were evaluated to determine if they were correct. During an interview on [DATE] at 2:25 p.m., CNA E said she had been in serviced regarding using the profile sheet, how to access it in the kiosk, and making sure to provide care according to the resident plan of care. She said she provided care according to resident care plans/profile sheets. During an interview on [DATE] at 2:30 p.m., CNA/MA F said she did not provide resident care often, but she was aware Resident #1 was a two person assist with care. She said she had completed an in service on transferring and providing ADL care. She said they had a lot of agency staff who worked and had to have a way of letting them know how to take care of the residents. During an interview on [DATE] at 2:33 p.m. LVN G said she had worked at the facility for 3 weeks. She knew Resident #1 had broken his legs and was on hospice due to pain. She said Resident #1 received PRN morphine every two hours and he also had Ativan for anxiety. She said when they provided care to Resident #1 it was always two people and sometimes 3 people just to reposition him. She said she received an in servicing on the resident profile and how to put the information in the system. She said the aides were required to complete a return demonstration of how to access the information from the computer system and there was a book on each hall with the profile information in it. During a telephone interview on [DATE] at 5:38 a.m., RN H said she worked PRN and had been working at the facility for 4 years. She said she was in serviced about Resident #1. She said she as a nurse, they were educated on how to get on the plan of care in POC and how to put the information in the computer for the Plan of care. (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	Record review of a Provider Investigation report indicated on [DATE] Resident #2 was noted with edema that started in the lower right extremity and moved up the leg. The Hospice agency gave an order for an x ray due to a possible fracture. The Resident was assessed and treated for pain. Staff were interviewed for possible information related to the cause of the injury. Resident safe surveys were conducted on the hall and no concerns were reported. The staff were [NAME]-serviced on care planned transfer techniques/gait belt. Through the investigation process it was reported Resident #2 was transferred with a standing-pivot transfer on [DATE]. There was no fall or adverse reaction at that time, the resident was transferred safely to bed. The resident had a diagnosis of osteoporosis (decreased bone density, weakened and brittle bones) and osteopenia (lower than normal bone density) which could have contributed to the femoral neck fracture when she was transferred to bed. Resident #2 was care planned for a Hoyer transfer and while she could stand and bear weight, this could potentially be the cause of the injury. The provider actions taken were the DON/Designee would re-educate nursing staff regarding following the plan of care which included the expectation that non-compliance would not be tolerated. This education was initiated on [DATE]. A list of statements provided by the Administrator on [DATE] at 3:10 p.m. was titled Confidential Attorney Work Product. with no date. Statements indicated staff were interviewed regarding knowledge of an injury to Resident #2 and no staff had any knowledge. During an interview with CNA C, she said 2-or-3 days prior she had assisted Resident #2 with a stand and pivot transfer from her wheelchair to the bed. According to CNA C, there were no issues noted during the transfer. CNA C said she did not know Resident #2 was a two person assist. She said she asked CNA A and CNA A told her Resident #2 could bear weight. The same form indicated CNA A said she told CNA C the resident could bear weight, but they used a Hoyer to transfer her. Record review of CNA C's personnel file indicated a hire date of [DATE]. There was a skills verification, checklist and competency check offs that were completed by CNA C on [DATE]. The check off indicated she was competent on physical and body mechanics, and the use of a transfer belt. She was also competent on observation and documentation correctly on flow sheets in the kiosk as facility specific. During an interview on [DATE] at 3:09 p.m., the Administrator said CNA C had not worked with Resident #2 and she asked CNA A about the resident. CNA C said CNA A told her Resident # 2 could stand and pivot. He said she apparently did not use the kiosk or profile sheet. He said they had a Mitigation binder for that incident. During an interview on [DATE] at 1:00 p.m., the DON said CNA C did an improper transfer and they suspended her. She said they could not prove that was the reason why Resident #2 had the broken hip. The DON said Resident #2 had not had any falls or events that could have caused the hip fracture. However, they were going to allow CNA C to return to work with training. She had not come back to the facility. During a telephone interview on [DATE] at 1:52 p.m., CNA A said CNA C asked her about Resident #2. She said she thought CNA C had misunderstood what she had said. CNA A said she told CNA C, Resident #2 was a Hoyer lift transfer, but other staff transferred her by standing and pivoting. She said Resident #2 did not show any pain after the transfer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676300	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Oaks	1901 S Trade Days Blvd Canton, TX 75103

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record a review of a Mitigation plan, dated [DATE], indicated the facility received notice on [DATE] that Resident #2 had a fracture of the femur. Residents were being treated by the facility per physicians orders. Residents with a potential to be affected were residents who resided in the facility and required assistance with mechanical lift. The director of nurses/designee educated nursing staff on following the plan of care, which included the expectation that noncompliance was not tolerated. The education was initiated on [DATE] and staff not completing by [DATE] would receive training prior to working next shift. The education would be presented in the new hire packet on [DATE] all staff were in-service and reeducated regarding the use of gate belts. Attached was a copy of an in-service on an abuse and neglect. Attached was a copy of the facility's, gate belt procedures, and a copy of the facility's, geriatric patient assessment and treatment. Record a review of the in-service that was attached to the mitigation plan indicated staff were in-serviced beginning on [DATE] on transfers, to check the profile of each resident prior to transfers prevent injuries. Ask for help if the resident seems more confused than usual and may need more help. They were to use a Hoyer for residents that listed on their profile under ADLs. There were also instructions for the kiosk to check the residents name and how to follow the instructions in the POC. During a telephone interview on [DATE] at 5:38 a.m., RN H said she worked PRN and had been working at the facility for 4 years. She said she was in serviced about Resident #2. She said she as a nurse was educated on how to get on the plan of care in POC and how to put the information in the computer for the Plan of care. During an interview on [DATE] at 5:41 a.m., RN I said she worked from 6 p.m. to 6 a.m. and had worked at the [TRUNCATED]