STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676327	A. Building B. Wing	06/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Healthcare and Rehabilitation	1500 Cottonwood Creek Trail Cedar Park, TX 78613

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 2 residents reviewed for accidents (Resident #1). The facility failed to ensure the side rails were up and locked in place on shower bed and CNA D did not shower Resident #1 with the assistance of a second staff, per the care plan, on 5/21/26. Resident #1 fell from the shower bed and hit her head which caused an injury requiring 4 staples. This deficiency could expose residents to harm and injury, due to not being adequately assisted. Finds include: Record review of Resident #1's face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1's diagnosis included impulse disorder, anxiety disorder, repeated falls, personal history of traumatic brain injury. Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected resident #1's BIMS score reflected 2 which indicated a moderately impaired cognition. The section GG for functional abilities for personal hygiene, and shower/bathe self was coded with a 01 which meant resident #1 was dependent - helper does all the effort.; resident did none of the effort to complete the activity; or the assistance or 2 or more helpers is required for the resident to complete the activity. Record review of Resident #1's comprehensive care plan dated 03/15/2019 that reflected the resident had an ADL self-care performance deficit related to weakness and debility with an intervention for bathing: I am dependent on 2 staff participation with bathing. Record review of an incident report dated 05/21/2026 revealed Resident # 1 fell from the shower bed in the shower room. Resident #1 was just placed on the shower bed and CNA D stated she adjusted the location of the lift so that she could have better access to the side of the shower bed. Before CNA D could step fully to the side of the shower bed, Resident #1 fell from the bed and hit her head on the leg of the lift. EMS transported Resident #1 to the hospital for further evaluation. Record review of Resident #1's progress notes dated 05/21/2026 at 5:49 PM reflected, 'CNA was getting resident ready for a shower when resident fell of the shower bed to the floor. CNA called out for help. Nurses rushed to help, 911 called. EMS took resident immediately to hospital. Staff stayed with resident and initiated First aide till Emergency help arrived. Resident made a statement, 'I am not in pain'. Resident followed instructions by answering all questions asked, doing ROM, scratching herself, talking, staff noted blood to the back of her head, pressure applied to back of head. Vitals read: T-97.8,137/85, 86,20,02sat 94%. ADON, DON, RP notified. RP to meet her mother at hospital.' During an interview on 06/06/2026 at 10:47 AM with CNA A, she stated when staff was not sure of how to care for a resident they could look it up in the Kardex (resident care guide), care plan or ask a nurse. CNA A stated when using the shower bed, to make sure to lock the wheels, raise the side rails and make sure they were locked in place with the pins. CNA A stated that if only 1 staff member was giving a shower to a resident who was a 2-person assistance the resident could fall and get hurt. During an interview on 06/06/2026 at 11:23 AM with CNA B, stated when using a shower bed, 2 staff members should always be used, make sure it is locked, put the rails up and locked with the pins so they do not slip and slide. When CNA B was asked how she knew how to care for a resident, she stated, by looking at the care plan in the charting system. When CNA B was asked what (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 0689 Level of Harm - Actual harm Residents Affected - Few	a potential negative outcome could be if a resident who was a 2-person shower assist was given a shower by 1 person she stated anything could happen including a fall. During an interview on 06/06/2026 at 11:37 AM with CNA C, she stated when using the shower bed, staff should ensure the wheels were locked, rails were up and locked. She stated a potential negative outcome of giving a shower to a resident who was a 2 person assist alone could be a fall resulting in injury. Interview on 06/06/2026 at 2:40 PM the DON stated CNA E came to her and said they needed her help in the 500-hall shower room. The DON said she ran to the shower room and saw Resident # 1 on the floor, getting assistance from CNA D, the ADON was already applying pressure to the back of her head. They switched places and she (DON) began telling everyone what to do, directing the CNA to go sit in her office and write a statement about what happened. The [NAME] said CNA D told her she had just transferred Resident # 1 to the shower bed that she was trying to move the mechanical lift to have a little more space to work in, CNA D had just barely turned her back and Resident # 1 quickly fell out of the shower bed, resulting in an injury to the back of the head requiring 4 staples. The DON stated CNA D stated the rails on the shower bed were not put up and locked in place. The DON stated her expectation for her staff was to follow the policy of the shower bed which was always 2 people and follow the resident's care plan interventions. The DON stated a possible negative outcome for the residents if policies and procedures were not followed could be injury. Interview on 06/06/2026 at 3:02 PM the ADM stated she learned of the incident with Resident # 1 when the EMS was called, the DON let her know what had happened then CNA D did a return demonstration, where she admitted she did not put up the side rails up on the shower bed. The ADM stated her expectation for her staff was to follow policies and procedures for items like the shower bed and mechanical lift which was 2 people use. She stated a possible negative outcome if policies and procedures were not followed could be potential injury for the resident. Interview on 06/06/2026 at 4:17 PM CNA D stated after transferring Resident # 1 to the shower bed she did not recall the side rails being put up and locked. CNA D stated she was giving Resident # 1 a shower in the shower bed by herself. CNA D said she turned for a second to pick up her washcloth with soap and Resident # 1 jumped out of the shower bed and fell on the ground hitting the back of her head on the leg of the mechanical lift. Interview on 06/06/2026 at 4:39 PM CNA E stated she helped CNA D transfer Resident # 1 to the shower bed safely and then left to go and assist her residents and do some documentation at the nurses' station. CNA E said CNA D went to the nurses' station looking for the nurse because she needed help, but the nurse was on break. CNA E stated I got up to see what was wrong and that is when she saw Resident # 1 on the floor. Record review of Bath, Shower/Tub policy dated February 2018 revealed under equipment and supplies the following equipment and supplies will be necessary when performing this procedure 1. Portable bath chair, some residents based upon medical needs & limitations may require a shower bed. This requires 2 staff to remain with the resident the entire time during the bathing process and both rails raised.