STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676331	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hunters Pond Rehabilitation and Healthcare	9903 Hunters Pond San Antonio, TX 78224

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interviews and record reviews the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 1 of 8 residents (Residents #1) reviewed for abuse and neglect. The facility failed to report to the SA when MA A provided incontinent care to Resident #1 alone. Resident #1 required two staff to assist with bed mobility (turning in bed). Resident #1 rolled out of bed during incontinent care with MA A, landed on her knees, broke both knees, and was hospitalized on [DATE]. These failures could place residents at risk for abuse and neglect. The findings included: Record review of Resident #1's admission record, dated 1/8/25, admitted on [DATE] revealed a [AGE] year-old female with diagnoses that included encephalopathy (any brain disorder or disease that affects the brain's structure or function), gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach. A feeding tube, also known as a G-tube, is inserted through the opening to deliver food, fluids, and medications directly to the stomach.), other cerebral palsy (a group of neurological disorders that affect a person's ability to move, maintain balance, and coordinate muscles), pressure ulcer of sacral region stage 4(a severe pressure sore located on the sacrum (the bony area at the base of the spine) where the skin and tissue damage extends deep into the underlying muscle, tendon, and potentially even bone), malignant neoplasm of unspecified site of unspecified female breast (a medical term for breast cancer where the exact location is unknown), muscle weakness, dysphagia (difficulty swallowing), and cognitive communication deficit. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's admission MDS, dated [DATE], revealed she had severely impaired cognition for daily decision making. Section GG functional ability showed she was dependent (Helper does ALL of the effort - resident does none of the effort to complete the activity - or, the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left and right. Record review of Resident #1's care plan, last revised 12/13/24, revealed she had an ADL self-care performance deficit related to cerebral palsy and she required staff participation to reposition and turn in bed. The care plan did not specify if she was a 1 or 2 person assist. Record review of Resident #1's daily skilled progress notes starting on 11/6/24 through 1/4/25 revealed that she was total assist of 2 with ADLs - bed mobility 2+ physical assist; totally dependent. Record review of Resident #1's OT evaluation, dated 11/7/24, written by OT E revealed Patient is current total Ax2 with bed mobility . OT provided demonstration and education with our skilled CNAs on bed mobility during changing of brief . Record review of a written statement, dated 1/4/25, written by MA A revealed she provided incontinent care to Resident #1 by herself, and Resident #1 fell off the bed, landing on her knees. Record review of Resident #1's x-ray results, taken 1/4/25, showed acute, traumatic, impacted supracondylar femoral fracture (break of the thighbone just above the knee joint) of the right and left knee. Record review of fall report, dated 1/4/25, for resident #1 was completed by LVN B, stated .The Resident was observed on the floor next to her bed, laying on her back CNA. stated she was providing incont/peri care During the process on repositioning the resident the residents' legs slipped of the bed onto the side of the bed in which the resident was initially in a praying position Assessed immediately for pain and injuries No physical injuries or skin tears observed at this time, but redness was noted to lower left knee Resident complains to pain to BLE. Stated her head does not hurt only her legs . The report stated the resident was alert and her mobility was bedridden. It stated the predisposing physiological factor was incontinent. Record review of TULIP on 1/8/25 at 5:00 p.m. showed there was no self report from the facility for the incident with Resident #1 on 1/4/25. During an interview on 1/8/25 at 4:29 p.m. CNA D stated she always had a second person assist her with Resident #1 because she was a 2 person assist and also because she was on an air mattress and they could be dangerous when turning a resident in bed. During an interview on 1/8/25 at 5:19 p.m. LVN C stated Resident #1 was a total assist and she would do everything for the resident because she could not do anything for herself. LVN C stated you needed two staff to help with incontinent care or turning. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 1:39 p.m. OT E stated Ax2 with bed mobility meant the resident required 2 persons for a brief change. OT E stated she would have shown the CNAs how to safely roll the resident for incontinent care to prevent injury to the resident or bruising. OT E stated she would use Ax2 for resident would need more physical excursion from the CNA to turn and therefore required a second person to safely turn and position the resident. During an interview on 1/8/25 at 4:50 p.m. MA A, stated she normally worked as a medication aide but had picked up a shift as a CNA on 1/4/25. MA A stated she believed the resident was a 1-2 person assist for incontinent care and felt confident she could change the resident by herself. MA A stated the resident was squirming and pulling herself during the care and she asked her to stay still and next thing she knew she fell on to the floor on to her knees. MA A stated she thought Resident #1 only needed one person to assist with turning in bed. MA A stated she had not had any formal in service or coaching as of 1/8/25 related to Resident #1 falling out of bed during incontinent care. During an interview on 1/8/25 at 6:25 p.m., LVN B stated Resident #1 was a 2 person assist when turning in bed. LVN B stated she was informed by MA A that Resident #1 fell during incontinent care. She stated she asked MA A why she did not come get her to assist with turning the resident and MA A stated I do not know. LVN B stated the resident was returned to bed and was able to communicate that she had pain at her knees. A mobile x-ray was done and found possible fractures. LVN B stated she was sent to the hospital, and she later spoke with the nurse at the hospital who stated she had fractures and were pending a decision if she would be cleared for surgery. During an interview on 1/9/25 at 3:12 p.m., MDS F stated she updated Resident #1's care plan on 12/13/25 in the mobility section. She stated the electronic medical records system gives prepopulated interventions that could apply, and she chose to check off Requires staff participation to reposition and turn in bed for bed mobility because some of the CNAs could change Resident #1's brief on their own and some of the CNAs needed assistance and could not change the resident's brief alone. MDS F stated although the MDS section GG noted the resident was dependent for bed mobility it did not mean she required 2 staff because hygiene was also dependent but did not require 2 staff to help her brush her teeth. During an interview on 1/8/25 at 5:39 p.m., the DON stated she received a call from LVN B on 1/4/25 about the fall Resident #1 had. She stated they did not understand the initial x-ray results, so they sent the resident to the hospital. The DON stated they had nothing conclusive from the hospital yet to know if she had fractures. The DON stated the Kardex or care plan showed the resident required 1 or 2 staff for assistance but upon looking further neither showed how many staff the resident required to assist and this could cause accidents. The DON stated going forward Resident #1 would be a 2 person assist and all residents with pressure reducing mattresses would require 2 staff to assist with turning to prevent falls. The DON stated she did not report the injury to HHSC because it was a witnessed fall. The DON stated she began in servicing staff on Monday 1/6/25 and in serviced MA A after her interview with surveyors on 1/8/25. The DON stated she had not had a chance to formally in-service MA A but had a conversation with MA A over the phone on 1/4/25. The DON stated MA A was off on 1/5/25 and 1/6/25. The DON did not provide a reason why the in-service was not done on 1/7/25 the day MA A returned to work. The DON stated on 1/8/25 MA A had to run an errand and then was interviewed by surveyors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment, dated 10/2022, stated Procedure: 1. In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: No Not later than two (2) hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury o Not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury 2. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: a. The Administrator of the Facility b. The State Survey Agency c. Adult Protective Services (as appropriate) 3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that the results of all investigations are reported within five (5) working days of the incident to: a. The Administrator b. The State Survey Agency 5. Ensure that, if the alleged violation is verified, appropriate corrective action is taken .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45857 Based on interview 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 includes measurable objective and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 8 residents (Resident #1) reviewed for care plans: The facility failed to develop a person-centered care plan with interventions that addressed Resident #1's need for 2 staff to assist with bed mobility. This failure could place residents at risk for not having their needs and preferences met. The findings were: Record review of Resident #1's admission record, dated 1/8/25, admitted on [DATE] revealed a [AGE] year-old female with diagnoses that included encephalopathy (any brain disorder or disease that affects the brain's structure or function), gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach. A feeding tube, also known as a G-tube, is inserted through the opening to deliver food, fluids, and medications directly to the stomach.), other cerebral palsy (a group of neurological disorders that affect a person's ability to move, maintain balance, and coordinate muscles), pressure ulcer of sacral region stage 4(a severe pressure sore located on the sacrum, the bony area at the base of the spine, where the skin and tissue damage extends deep into the underlying muscle, tendon, and potentially even bone), malignant neoplasm of unspecified site of unspecified female breast (a medical term for breast cancer where the exact location is unknown), muscle weakness, dysphagia (difficulty swallowing), and cognitive communication deficit. Record review of Resident #1's admission MDS, dated [DATE], revealed she had severely impaired cognition for daily decision making. Section GG showed she was dependent (Helper does ALL of the effort - resident does none of the effort to complete the activity - or the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left and right. Record review of Resident #1's care plan, last revised 12/13/24, revealed she had an ADL self-care performance deficit related to cerebral palsy and she required staff participation to reposition and turn in bed. The care plan did not specify if she was a 1 or 2 person assist. Record review of Resident #1's daily skilled progress notes starting on 11/6/24 through 1/4/25 revealed that she was total assist of 2 with ADLs - bed mobility 2+ physical assist; totally dependent. Record review of Resident #1's OT evaluation, dated 11/7/24, written by OT E revealed Patient is current total Ax2 with bed mobility . OT provided demonstration and education with our skilled CNAs on bed mobility during changing of brief . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 3:12 p.m., MDS F stated she updated Resident #1's care plan on 12/13/25 in the mobility section. She stated the electronic medical records system gives prepopulated interventions that could apply, and she chose to check off Requires staff participation to reposition and turn in bed for bed mobility because some of the CNAs could change Resident #1's brief on their own and some of the CNA's needed assistance and could not change the resident's brief alone. MDS F stated although the MDS section GG noted the resident was dependent for bed mobility it did not mean she required 2 staff because hygiene was also dependent but did not require 2 staff to help her brush her teeth. During an interview on 1/8/25 at 5:39 p.m., the DON stated the Kardex (documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) or care plan showed the resident required 1 or 2 staff for assistance but upon looking further neither showed how many staff the resident required to assist, and this could cause accidents. The DON stated going forward Resident #1 would be a 2 person assist and all residents with pressure reducing mattresses would require 2 staff to assist with turning to prevent falls. Record review of a facility policy, titled Nursing Administration, dated 5/2007, revealed: Section: Care and Treatment Subject: Care Planning POLICY: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident 1. A comprehensive care plan is developed within seven (7) days of completion of the Resident Minimum Data Set (MDS) 2. The care plan is developed by the IDT .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #1) of 8 residents reviewed for accidents and hazards. MA A failed to have another staff assist while providing care for Resident #1 in the bed on 1/4/25. Resident #1 rolled out of the bed, fell to the floor, landed on her knees, and fractured both knees. Resident #1 was hospitalized after. An IJ was identified on 1/9/25. The IJ template was provided to the facility on [DATE] at 5:09 p.m. While the IJ was removed on 1/10/25 the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because the facility needed to monitor the implementation of the plan of removal. The failure placed residents at risk for serious injury, harm, and/or death. The findings included: Record review of Resident #1's admission record, dated 1/8/25, admitted on [DATE] revealed a [AGE] year-old female with diagnoses that included encephalopathy (any brain disorder or disease that affects the brain's structure or function), gastrostomy status (a surgical procedure that creates an opening in the abdomen and into the stomach. A feeding tube, also known as a G-tube, is inserted through the opening to deliver food, fluids, and medications directly to the stomach.), other cerebral palsy (a group of neurological disorders that affect a person's ability to move, maintain balance, and coordinate muscles), muscle weakness, and cognitive communication deficit. Record review of Resident #1's admission MDS, dated [DATE], revealed she had severely impaired cognition for daily decision making. Section GG showed she was dependent (Helper does ALL of the effort - resident does none of the effort to complete the activity - or the assistance of 2 or more helpers is required for the resident to complete the activity) with rolling left and right. Section H for bladder and bowel showed the resident had a indwelling catheter and was always incontinent of bowel and bladder. Record review of Resident #1's care plan, last revised 12/13/24, revealed she had an ADL self-care performance deficit related to cerebral palsy and she required staff participation to reposition and turn in bed. The care plan did not specify if she was a 1 or 2 person assist. Record review of Resident #1's visual/bedside Kardex report, dated 1/8/25, showed: Transfers BED MOBILITY(ROLL LEFT AND RIGHT, SIT TOLYING, LYING TO SITTING ON SIDE OF BED):Requires staff participation to reposition and turn in bed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Bed Mobility TRANSFER(CHAIR/BED TO CHAIR TRANSFER,TOILET TRANSFER)): Requires staff participation with transfers. Record review of Resident #1's daily skilled progress notes starting on 11/6/24 through 1/4/25 revealed that she was total assist of 2 with ADLs - bed mobility 2+ physical assist; totally dependent. Record review of Resident #1's nursing progress note, dated 1/4/25, written by LVN B stated: -3:59 p.m. resident s/p witnessed fall. Vital signs are stable at this time. No physical injuries or skin tears noted. Some redness to BLE. Resident does complain of pain. Family and NP. aware. New order to Xray BLE. Resident now resting in bed with call light in reach. Bed is in lowest, locked position. Door remains open for additional observation. -5:49 p.m. Sending to ER to rule out any fractures. [Transport Company] ETA 30-45 minutes from this time. -6:47 p.m. [Transport Company] picked up resident at this time. Resident still alert and oriented upon leaving, No nonverbal indicators of pain noted. Report given to [Hospital] [Nurse] ER RN. -1/5/25 9:45 a.m. Called .hospital and spoke with .RN about plan of care. RN stated resident is still pending consultations with hospitalist, cardiologist, and orthopedic physicians for final say, right now we are just managing her pain and nutrition status. Not discharging at this time. Relocated resident bed against wall for fall precaution and floor mat in place. Pending discharge from hospital. Record review of Resident #1's OT evaluation, dated 11/7/24, written by OT E revealed Patient is current total Ax2 with bed mobility . OT provided demonstration and education with our skilled CNAs on bed mobility during changing of brief . Record review of a written statement, dated 1/4/25, written by MA A revealed she provided incontinent care to Resident #1 by herself, and Resident #1 fell off the bed, landing on her knees. Record review of Resident #1's x-ray results, taken 1/4/25, showed acute, traumatic, impacted supracondylar femoral fracture of the right and left knee. Record review of Resident #1's hospital records, printed 1/10/25, stated she was admitted on [DATE] for witnessed fall, hit both knees and side of head with no loss of consciousness. The doctor noted because the resident was non-ambulatory and also had cancer, they would not provide surgical intervention. The Xray of the left and right knee results stated: 1. Osteoporosis (disease in which your bones become weak and are likely to fracture (break)) and multifocal osseous metastatic disease (when cancer from one part of the body spreads to the bones. These metastases can be osteolytic or osteoblastic, causing bone destruction or new bone formation). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Age-indeterminate pathologic fracture of the right acetabulum (break in the socket portion of the hip joint) with involvement of the posterior column (the back part of the hip socket). Consider further characterization with CT. 3. Comminuted (a type of bone fracture that is broken in at least two places or multiple fragments) and displaced fractures (the bone snaps into two or more parts and moves so that the two ends are not lined up straight) of bilateral distal femoral metaphysis (end of the thigh bone) with intra-articular extension into the knee joint (bone fracture in which the break crosses into the surface of a joint. This always results in damage to the cartilage.) bilaterally. 4. Suspected nondisplaced (bone cracks or breaks but retains its proper alignment and position) bilateral inferior patella (knee cap) fractures. 5. Chronic (old) appearing fractures of the left superior pubic ramus (pelvic area) and left proximal (position in a limb that is nearer to the point of attachment) fibular diaphysis (The fibular diaphysis is the shaft of the fibula, which is one of the two bones of the lower leg. It is situated between the knee and ankle and helps keep the ankle joint stable). Record review of fall report, dated 1/4/25, for resident #1 was completed by LVN B, stated .The Resident was observed on the floor next to her bed, laying on her back CNA. stated she was providing incont/peri care During the process on repositioning the resident the residents' legs slipped of the bed onto the side of the bed in which the resident was initially in a praying position Assessed immediately for pain and injuries No physical injuries or skin tears observed at this time, but redness was noted to lower left knee Resident complains to pain to BLE. Stated her head does not hurt only her legs . The report stated the resident was alert and her mobility was bedridden. It stated the predisposing physiological factor was incontinent. During an interview on 1/8/25 at 4:29 p.m. CNA D stated she worked on 1/4/25 with MA A but was showering another resident at the time MA A dropped Resident #1. CNA D stated she always had a second person assist her with Resident #1 because she was a 2 person assist and also because she was on an air mattress and they could be dangerous when turning a resident in bed. During an interview on 1/9/25 at 1:39 p.m., OT E stated Ax2 with bed mobility meant the resident required 2 persons for a brief change. OT E stated she would have shown the CNAs how to safely roll the resident for incontinent care to prevent injury to the resident or bruising. OT E stated she would use Ax2 for resident would need more physical excursion from the CNA to turn and therefore required a second person to safely turn and position the resident. During an interview on 1/8/25 at 4:50 p.m., MA A stated she normally worked as a medication aide but had picked up a shift as a CNA on 1/4/25. MA A stated she believed the resident was a 1-2 person assist for incontinent care and felt confident she could change the resident by herself. The MA stated the resident was squirming and pulling herself during the care and she asked her to stay still and next thing she knew she fell on to the floor on to her knees. MA stated she thought Resident #1 only need one person to assist with turning in bed. MA A stated she had not had any formal in service or coaching as of 1/8/25 related to Resident #1 falling out of bed during incontinent care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/8/25 at 6:25 p.m., LVN B stated Resident #1 was a 2 person assist when turning in bed. LVN B stated she was informed by MA A that Resident #1 fell during incontinent care. She stated she asked MA A why she did not come get her to assist with turning the resident and MA A stated she did not know. LVN B stated the resident was returned to bed and was able to communicate that she had pain at her knees. A mobile x-ray was done and found possible fractures. LVN B stated she was sent to the hospital, and she later spoke with the nurse at the hospital who stated she had fractures and were pending a decision if she would be cleared for surgery. During an interview on 1/9/25 at 3:12 p.m., with MDS F stated she updated Resident #1's care plan on 12/13/25 in the mobility section. She stated the electronic medical records system gives prepopulated interventions that could apply, and she chose to check off Requires staff participation to reposition and turn in bed for bed mobility because some of the CNA could change Resident #1's brief on their own and some of the CNA's needed assistance and could not change the resident's brief alone. MDS F stated although the MDS section GG noted the resident was dependent for bed mobility it did not mean she required 2 staff because hygiene was also dependent but did not require 2 staff to help her brush her teeth. During an interview on 1/8/25 at 5:39 p.m., the DON stated she received a call from LVN B on 1/4/25 about the fall Resident #1 had. She stated they did not understand the initial x-ray results, so they sent the resident to the hospital. The DON stated they had nothing conclusive from the hospital yet to know if she had fractures. The DON stated the Kardex, or care plan showed the resident required 1 or 2 staff for assistance but upon looking further neither showed how many staff the resident required to assist and this could cause accidents. The DON stated going forward Resident #1 would be a 2 person assist and all residents with pressure reducing mattresses would require 2 staff to assist with turning to prevent falls. The DON stated she did not report the injury to HHSC because it was a witnessed fall. The DON stated she began in servicing staff on Monday 1/6/25 and in serviced MA A after her interview with surveyors on 1/8/25. Record review of facility policy titled Fall Management System. Dated 12/2023, stated It is the policy of this facility to provide an environment that remains as free of accident hazards as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs . 2. Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. a. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk . An Immediate Jeopardy was identified on 1/9/25 The Administrator and the DON were notified of the Immediate Jeopardy on 1/9/25 at 5:09 p.m. and were given a copy of the IJ template and a Plan of Removal (POR) was requested. The facility's Plan of Removal for the Immediate Jeopardy was accepted on 1/10/25 at 12:30 p.m. and reflected the following: [Nursing Home] Plan of Removal 1/9/25 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Per IJ Template F689- Incidents/Accidents Immediate Action o Medical Director notified of Immediate Jeopardy on 1/9/25 @ 1811 (6:11 p.m.). o Resident RP .was notified of Immediate Jeopardy on 1/9/25 @2002 (8:02 p.m.) o Resident #1 was sent to [Hospital] on 1/4/25 and is no longer in the facility. o The following in-services were conducted: Abuse and Neglect at 100% for all staff, Review of Kardex to determine who is a 2 person assist with ADL-bed mobility to all licensed nurses, CNA's and CMA' at 100%, OT and PT were in-serviced at 100% on evaluating new admissions to determine ADL-bed mobility status, and all licensed nurses were in-serviced at 100% to refer to special instructions in resident's care profile to ensure ADL-bed mobility documentation is accurate, starting on 1/9/25 and completed on 1/10/25 by 1 pm. Any employee not receiving in-services will not be allowed to work their shift until in-services have been received. In-services will be in person or via phone. o An audit of resident ADL's- bed mobility to identify residents who require 2 persons assist completed at 100% by nursing and therapy services to be completed on 1/10/25 by 1 pm. o Any resident's identified as 2 persons assist for ADL's-bed mobility will be added to the Kardex/Careplan and Special Instructions in the resident's care profile to be completed on 1/10/25 by 1 pm. o CNA A (CNA A is the same person as MA A) was in-serviced 1:1 on 2 persons assist for ADLs- bed mobility and referring to Kardex for ADL- bed mobility status to be completed on 1/10/25 by 1pm. o Residents safe surveys were starting on 1/9/25 and to be completed on 1/10/25 by 1pm. o Residents safe surveys were starting on 1/9/25 and to be completed on 1/10/25 by 1pm. Identification of Others Affected All residents who require 2 persons assist with ADLs-bed mobility have the potential to be affected by this alleged deficient practice. Systemic Change to Prevent Re-occurrence. 1. DON/ADON started in-services on Abuse and Neglect at 100% for all staff, Review of Kardex to determine who is a 2 person assist with ADL-bed mobility to all licensed nurses, CNA's and CMA's at 100%, all licensed nurses were in-serviced at 100% to refer to special instructions in resident's care profile to ensure ADL-bed mobility documentation is accurate to be completed on 1/10/25 by 1pm. Any employee not receiving in services will not be allowed to work their shift until in-services have been received. In-services will be in person or via phone. 2. Starting on 1/9/25 an audit of resident ADL's- bed mobility to identify residents who require 2 persons assist completed at 100% by nursing and therapy services to be completed on 1/10/25 by 1 pm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. Summary of IJ and corrective action to be reviewed by QAPI monthly until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. The facility's POR Verification was as follows: Record review of POR binder note stated Medical Director was notified of Immediate Jeopardy on 1/9/25 at 6:11 PM. Interview on 1/10/25 at 4:19 p.m., the Medical Director stated she had not spoken to the facility about an IJ, and it may have been in her call log. The Medical Director stated there are several reasons a resident might need more assistance with bed mobility and was based on the ability of the patient. She stated for example weight issues could require the resident to need more assistance. She stated the type of assistance needed was dependent on the residents needs and abilities. Interview on 1/10/25 at 7:00 p.m., the DON she left a message on 1/9/25 for the Medical Director. The DON showed her call log and a call lasting 46 seconds at 6:11 p.m. was on the call log. Interview on 1/8/25 at 3:00 PM, Resident #1's RP was interviewed and stated another emergency contact had more information about what happened to the resident the day of the fall and referred the surveyors to speak to that contact. Review of EHR progress notes of Resident #1 stated RP was notified of Immediate Jeopardy on 1/9/25 at 8:02 PM. Interview on 1/10/25 at 7:00 p.m., the DON stated she told the RP what happened and because of what happened and an IJ was called. The RP stated she would pass the message onto the emergency contact #2. Record review of Resident #1's EHR progress notes dated 1/4/25 at 6:47 p.m. stated resident was transferred to [hospital] via EMS. During an Observation on 1/9/25 at 8:53 a.m. Resident #1 was at the hospital. Resident #1 was asleep in bed and non-interviewable. The hospital Case Worker stated the resident had broken bones in her legs and was not a candidate for surgery. The Case Worker stated they were just making the resident comfortable and she would most likely discharge home as the family wanted. Record review of in-service titled Abuse, Neglect, and Exploitation, dated 1/9/25 contained 143 of 143 scheduled staff signatures present in plan of removal binder. Record review of in-service titled 2 Person Assist for ADL/Bed Mobility with Review of Kardex conducted on 1/9/25 with scheduled staff signatures present (89 total, 56 of 56 CNAs, CMAs, or HA signed the in-service, and 33 Licensed Nurses). Record review of in-service titled Kardex and Bed Mobility, dated 1/10/25, showed PT, OT, and ST with 25 of 25 scheduled staff signatures present. During an interview on 1/10/25 at 7:00 p.m., the DON stated she participated in training for staff by demonstrating to staff where to locate the kardex, special instructions, POC, and care plans. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 1/10/25 at 2:23 p.m., the DON stated they gathered input from rehab department for any residents they had prior PT, OT, ST, evaluations done on, and CNAs input to compile a list of residents who needed +2 assistance with bed mobility. Record review of active resident list was used to audit 115 residents and showed an updated list of residents with clarification of the type of mobility assistance they required. On 1/10/25 a random sample from taken from the Resident audit list. The kardex was reviewed of each resident and were updated with ADL-bed mobility status for bed mobility and transfers the following sampled residents: Resident #2 +2, +2 Resident #3 +1, +1 Resident #4 +2, +2 Resident #5 +2, +1 Resident #6 +2, +2 Resident #7 +2, +2 Resident #8 +1, +1 Resident #9 +2, +2 Resident #10 +2, +1 Resident #11 +1, +1. During an interview on 1/10/25 at 7:00 p.m., the DON stated every resident care plan was updated to state how many persons are required for assistance with bed mobility and transfers. Record review of in-service titled 2 Person Assist for ADL/Bed Mobility with Review of Kardex conducted on 1/9/25 contained MA A's signature. Interview on 1/10/25 with MA A at 6:17 p.m., she said LVN H did the in service with her 1 to 1, and another nurse watched her to the ADL portion. During an interview on 1/10/25 at 7:00 p.m. the DON stated she re-iterated to MA A she should ask for assistance with a resident if she was unsure of the type of assistance the resident required. The DON stated MA A normally worked as a medication aide and may not have been as familiar with the type of assistance the resident needed with mobility. . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of POR binder on 1/10/25 revealed 20 resident safe surveys were completed and no concerns were noted. During an interview on 1/10/25 at 7:00 p.m. the DON stated the AITs and DONs came into help complete the safe surveys. Nothing was reported of concern. Record review of POR binder revealed a document, dated 1/10/25, for an Off Cycle QAPI with staff signatures present. Record review on 1/10/25 a sample of residents' EHR Kardex for Resident #12, Resident #13, Resident #14, Resident #15, and Resident #16 were updated for 2 persons assist for transfers and bed mobility. Previously their kardex and care plans had not stated the number of staff needed for transfers. Interview on 1/10/25 at 6:55 p.m., . MDS F stated the facility will determine new admissions mobility needs and document them for staff to reference by looking at the last 3 days of assessment documentation from the nurse after a resident is admitted . MDS F stated the nurse does the documentation for 3 days under the GG assessment then they compared it with therapy assessments. MDS F stated the DOR did a verbal with them during daily meetings and would review the PT and OT documentation. They would verify it is accurate and matches the nurse and PT assessments. MDS F stated typically, PT, OT, or ST would try to see the Resident next day after admission for an assessment or if they were admitted early enough they could complete the assessment the same day. During an interview on 1/10/25 at 7:00 p.m., the DON stated they would verify with MDS new admissions, the DOR will give them updates, and discuss anyone she had done an assessment on and require a 2 person assist. Record review on 1/10/25 showed a log with one upcoming new hire notated to be trained at first shift so far. During an interview on 1/10/25 at 7:00 p.m. the DON stated they had called in mostly everyone who was new to complete the in-service and training. The DON stated any new hires after that would train with HR to do the sit-down orientation. During an interview on 1/10/25 at 6:48 p.m. with MDS F said they started a log with new admissions from 1/9/25. They looked at them to make sure their ADLs were checked, the nurse completed the assessments until therapy was able to evaluate them. All 3 new admission residents had the assessments done. MDS F stated they planned to fill out the audit log weekly. MDS F stated they corrected all the care plans, kardex, and special instructions to specify if the resident needed one or two people to assist. Record review of report dated 1/9/25, showed a new admission and discharge of residents in the facility with 3 residents on it for new admissions. Record review of document titled new assessment/care plan/Kardex log, dated January 2025, showed 2 MDS nurses and the DON signed that they looked at the 3 new resident admissions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 01/10/25 at 4:07 p.m. ADON J stated the bed mobility competency were done by her LVN K, LVN H, and LVN L, and maybe LVN M. ADON J stated they watched staff they were training perform perineal care and would guide them on the correct way as needed. Record review of documents titled Persons Needing Assistance with Bed Mobility, dated 1/9/25-1/10/25, showed 70 direct care staff (LVNs, RNs, CNAs, MAs, and HAs) completed skills check off for this competency on 1/9/25 though 1/10/25. 12 staff from the staff list did not have competency check offs because they were either no longer working at the facility or were PRN staff that were not scheduled to work till after 1/10/25. Interviews conducted on 1/10/25 between 3:49 p.m. to 7:44 p.m. with 20 staff (MA I, CNA S, CNA T, OT U, CNA V, CNA W, CNA Q, CNA Z, CNA D, CNA AA, CNA BB, CNA P, CNA CC, MA A, CNA Y, LVN K, LVN DD, and LVN C) from various shifts who all stated they received the in service and hands on training for residents who needed assistance with mobility and how to locate the information in the medical records. During an interview on 1/10/25 at 7:00 p.m., the DON stated nurse managers will oversee training new hires, but they also planned to hire a staffing developer with a start date of 2.4.25 to assist with training. The DON stated she would review any resident requiring 2 persons assist with ADL-bed mobility was added to care plan/Kardex and special instructions of resident's care profile and review this in QUAPI meetings. Record review of POR binder with in-services of nurse managers on 01/10/25 given by DON. All topics on the POR were reviewed. 8 staff signed the in service. Record review of document titled verification of care plan and kardex log had 4 staff names, 2 staff with additional required teachings, and signed off by the DON. Record review of document titled verification log new assessment/careplan/kardex showed a log with the resident, date, and signature for both MDS and DON who verified it. During an interview on 1/10/25 at 7:00 p.m. the DON stated verification of proper bed mobility log was completed by MDS G who observed two CNAs on 1/10/25. The log was filled out with this information and placed in the POR binder. During an interview on 1/10/25 at 7:00 p.m. the DON stated they had an off cycle QAPI and discussed how they were going to move forward. The DON stated they had the meeting on 1/10/25 and a log of this was placed in the POR binder. On 1/10/25 at 8:55 p.m., the Administrator was notified the IJ was removed. While the IJ was removed on 1/10/25 at 8:50 p.m. the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need to monitor the implementation of the plan of removal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45857 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection for 2 of 8 residents (Resident #14 and Resident #16) reviewed for infection control 1. The facility failed to ensure CNA D used appropriate hand hygiene between glove changes when providing incontinent care to Resident #14. 2. The facility failed to ensure Resident #16's catheter bag was not laying on the floor. These deficient practices could place residents at-risk for infection due to improper care practices. The findings included: 1. Record review of the Admission Record, dated 1/8/25, reflected Resident #14 was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included morbid severe obesity due to excess calories, chronic kidney disease stage 3 (the kidneys are moderately damaged and are not filtering waste and fluid properly), unsteadiness on feet, cognitive communication deficit, and muscle weakness. Record review of Resident #14's annual MDS assessment, dated 12/27/24, showed her memory was moderately impaired for daily decision making. Section H showed the resident was always incontinent of bladder and bowel. Record review of the Resident #14's Care Plan, initiated 1/1/25 and revised 1/7/25, showed she was receiving imipenem (antibiotic) 500 mg three times a day for 7 days for a UTI with interventions to encourage adequate fluid intake, give antibiotics, monitor for side effects, and use enhanced barrier precautions. Resident #14 had bowel/bladder incontinence related to impaired mobility and muscle weakness initiated on 12/8/20 and revised on 12/17/24 with interventions to check as required for incontinence. Wash, rinse, and dry perineum. Change clothing PRN after incontinence episodes. Observe/document for signs and symptoms of UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. During an observation on 1/9/25 at 4:43 p.m., CNA D provided incontinent care to Resident #14. CNA D wiped the resident's peri area, removed her gloves, did not perform hand hygiene, and put on new gloves. CNA D wiped Resident #14's buttocks area did not remove her gloves. CNA D then applied medicated cream to the resident's buttocks. With the same gloves still on CNA D then put a new clean brief on Resident #14. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/9/25 at 4:56 p.m., CNA D stated they were provided hand sanitizer to use in the room. CNA D stated she forgot to bring and use hand sanitizer during the incontinent care because she was nervous and wanted to hurry and finish. CNA D stated she was unsure if she should sanitize her hands between each glove change but should change them when going from a dirty to a clean area to prevent infection to the resident. During an interview on 1/10/25 at 10:05 a.m., the DON stated staff should perform hand hygiene between when going from dirty to clean. The DON stated she was unsure if staff needed to perform hand hygiene between each glove change and stated she would need to look at the facility policy. During an interview on 1/10/25 at 10:49 a.m., ADON J stated staff was expected to sanitize their hands between glove changes. ADON J stated one aide should handle the dirty tasks, such as cleaning the resident, while the other remains clean to manage clean tasks. ADON J stated once the resident is cleaned, gloves should be removed, hands sanitized, and new gloves put on before applying a clean brief. ADON J stated infections could occur if staff failed to perform proper hand hygiene. 2. Record review of the Admission Record, dated 1/8/25, reflected Resident #16 was a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included urinary tract infection, bladder neck obstruction (a blockage in the bladder neck that prevents urine from flowing out of the body), obstructive and reflux uropathy (condition in which the flow of urine is blocked), acute kidney injury (a sudden condition that damages the kidneys and reduces their ability to filter waste from the blood), severe sepsis without septic shock (a stage of sepsis that occurs when the body's immune system overreacts to an infection and damages organs, but blood pressure remains normal), abnormalities of gait and mobility, cognitive communication deficit, colostomy status, and muscle weakness. Record review of the Resident #16's Care Plan, initiated on 4/16/21 and revised last on 8/15/24, stated he had a suprapubic catheter with interventions to position catheter bag and tubing below the level of the bladder and away from entrance room door, had suprapubic catheter 16fr/10ml, provide catheter care every shift and as needed, measure urinary output, monitor and document intake and output as per facility policy, Monitor/record/report to MD for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns, and use enhanced barrier precautions. Record review of Resident #16's physician orders, dated 1/8/25, reflected an order for suprapubic catheter cleanse suprapubic site with normal saline or soap and water, pat dry, and secure with split sponge gauze twice a day every shift, with a start date of 6/4/24, and no end date. During an observation on 1/8/25 at 11:21 a.m., Resident #16 was in bed. His catheter bag was laying on the floor and did not have a cover or bag over it. The resident stated he did not know how it got on the floor. The resident stated he needed staffs' assistance to get in and out of bed. During an interview on 1/8/25 at 11:22 a.m., CNA O stated the catheter bag should not be on the floor because it is dirty. CAN O stated she personally had not been in the room to check on Resident #16 that day but knew the other aides CNA P and CNA Q had. CNA O picked the bag up off the floor and emptied the contents. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/25 at 11:38 a.m., CNA Q stated she worked as restorative aide and had obtained Resident #16's weight that day. She stated she did move the catheter to obtain his weight but placed it back on the side of the bed off the floor. CNA Q stated she was not sure how the catheter bag got on the floor. During an interview on 1/8/25 at 12:00 p.m., CNA P stated Resident #16 often did not like to be bothered and preferred to call staff for help. CNA P stated she had gone in his room earlier and he refused to let them change his sheet or provide care but did let them weigh him. CNA P stated she would let the nurse know if he continued to refuse care. CNA P stated they usually put a cover over the catheter bags to keep it from being exposed, breaking open, or getting pulled on. CNA P stated the catheter bag should not be on the floor. During an interview on 1/10/25 at 10:08 a.m., the DON stated the catheter should not be on the floor because of infection control. Record review of the facility's policy titled Indwelling Urinary Catheter Care, dated 12/23, stated It is the policy of this facility that each resident with an indwelling catheter will receive catheter care daily and as needed (PRN) to promote hygiene, comfort, and decrease the risk of infection . 13. Maintain the drainage tubing below the level of the bladder. 14. Cover the drainage bag with a privacy bag to maintain dignity . The DON was asked to provide a hand hygiene policy on 1/10/25 at 10:05 a.m. and it was not provided before exit. The facility provided a policy over the steps of hand washing only.