STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices based on the comprehensive assessment of resident (Resident #1) 1 of 6 residents reviewed for quality of care. -The facility failed to ensure staff remained with Resident #1 after Resident #1 was found on the floor, bleeding from his head. -The facility failed to complete an appropriate assessment for Resident #1 after an unwitnessed fall, where a laceration to the head and skin tear to the shoulder were sustained. These failures could place residents at risk of not receiving needed care and services to meet their physical, mental, and psychosocial needs. Findings include: 1. Record review of Resident #1's face sheet dated 04/16/24, revealed he was admitted to the facility on [DATE] with diagnoses of idiopathic peripheral autonomic neuropathy (peripheral nerve damage); malignant neoplasm of head, face and neck (head and neck cancer); right clavicle fracture (broken right collar bone), unsteadiness on feet; abnormalities of gait and mobility (weakness of and lower extremity muscles); chronic pain (unspecified, localized pain); and, muscle wasting and atrophy (decrease in size and wasting of muscle tissue). Record review of Resident #1's MDS dated [DATE], revealed the resident's BIMS score was 7, which indicated severe cognitive impairment. Resident #1 used a wheelchair and required maximum assistance with transferring to and from a bed to a wheelchair; moderate assistance with bathing, upper body dressing and personal hygiene; and supervision or touching assistance with eating and oral hygiene. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's care plan revealed he was at risk for fall related to decreased mobility and frequent falls at home prior to admission. Further review indicated the resident had potential for injury due to unsafe independent transfers. Interventions included assisting the resident with wearing non-slick footwear; monitoring the resident for increases in pain, redness and warmth of the legs; educating and encouraging the resident to use the call light for help with tasks requiring balance and standing positions; ensuring the resident's call light was within reach; and, transfers with assist of one to two staff with a gait belt or stand aid or, two or more staff with a mechanical lift. Record Review of Resident #1's electronic health record, revealed the following: Fall Risk Assessment on 04/14/24, the resident was considered a high fall risk and experienced 1 to 2 falls in the past 3 months; no recent changes in medication; suffered from dizziness, joint pain, and Parkinson's Disease; fall prevention protocol and care plan updated. The resident was not experiencing pain at this time but was at risk for pain due to current cancer diagnosis, history of chronic pain and previous injury. Further review revealed pain medication was administered. Record Review of Resident #1's SBAR on 04/14/24, revealed the following: The SBAR, completed by LVN A, did not reveal results of his range of motion assessment; the size, depth and amount of bleeding or drainage from Resident #1's laceration; nor, the size, amount and color/discoloration of his observed hematoma on his head. SBAR on 04/14/24, BP:109 54 Pulse:58 Respiratory Rate:18 Temperature:97.6 Oximetry %:96. No changes observed with the resident's mental status, behavioral, respiratory, cardiovascular, abdominal/GI, urine, and neurological evaluations. The resident's functional status was noted as general weakness compared to his baseline. Abrasion, laceration, skin tear and wound noted during skin evaluation. Further review of the SBAR revealed, Patient was on the floor bleeding from a hematoma to the forehead. There was also a small skin tear on the back of the right shoulder. Patient was awake, alert and oriented x 4. Talking. could recount what happened and how he fell . Trying to transfer from bed to wheelchair and lost balance. NP noted to have been notified at 4:30 PM on 04/14/24. Record Review of Resident #1's clinical notes on 04/14/24, revealed the following: The clinical note did not reveal Resident #1's pain using the 0-10 pain scale; results of Resident #1's range of motion assessment; the size, depth and amount of bleeding or drainage from Resident #1's laceration; nor, the size, amount and color/discoloration of his observed hematoma on his head. LVN A wrote, CNA responded to yelling coming from patient's room. Patient was observed on the floor adjacent to his bed bleeding from his head. Write did full head to toe assessment. Patient was alert and oriented x4. Only injuries noted was a knot above the right eyebrow on his forehead and small skin tear on the back of his right shoulder. First aid was done and TAO and dressing was applied. PRN Norco 10-325mg was also administered at this time. He reported that he was trying to get into his wheel chair to come out of the room and ask for help. SN reeducated the patient on the importance of using the call light and he verbalized understanding. Neuro check have been started and all responsible parties (RP, MD, UM & DON) were notified of incident. Care ongoing. Resident is listed as his own RP. Record Review of Resident #1's Treatment Notes, revealed the following: An order for neuro checks every 15 minutes for 1 hour; every 30 minutes for 2 hours; every hour for 5 hours; and, every 4 hours for 24 hours began on 04/14/24 at 4:15 PM. LVN A recorded Resident #1's Blood Pressure 109/54, Pulse 58, Respiration 18, Temperature 97.6, equal hand grasps, and normal motor function on 04/14/24 at 4:15 PM, 4:30 PM, 5:00 PM, 5:30 PM and 6:00 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Further review of Resident #1's Treatment Notes, revealed RN A recorded Blood Pressure 140/64, Pulse 64, Respiration 18, Temperature 97.6, equal hand grasps, and normal motor function on 04/14/24 at 6:30 PM; Blood Pressure 174/78, Pulse 60, Respiration 18, Temperature 97.6, equal hand grasps, and normal motor function on 04/14/24 at 7:00 PM; Blood Pressure 134/80, Pulse 62, Respiration 18, Temperature 97.8, equal hand grasps, and normal motor function on 04/14/24 at 8:00 PM. Further review of Resident #1's Treatment Notes revealed, neuro checks were not completed for Resident #1 between 8:00 PM on 04/14/24 through 8:00 AM on 04/15/24 while the resident was sent out to the hospital. Further review of clinical notes on 04/14/24, revealed: at 9:57 PM, RN A wrote, The pt was received resting in bed, alert and able to make his needs known. Outgoing nurse reported pt had a fall at about 4 pm today and had sustained head injury to the right side of his forehead with skin tear, bruising and swelling on the forehead. The nurse also reported NP was notified and had given order to monitor pt and to send pt to hospital for any change in his condition, pt on neuro-checks. The nurse also reported she had given the pt pain medication for the pain to his forehead. At about 7:30 PM neuro-checks was done, pt c/o headache to the forehead, the site of the injury, swelling to the forehead looked increased, vitals T 97.6 R 18 BP 174/78, P 60, O2 sats on room air 87-90%, initiated O2 2L via N/C, sats 95%, NP notified, order was received to send the pt to ER for evaluation. Pt. was notified, he requested to be sent to the hospital in The Woodlands, Pt was picked up by EMS at about 20:48, vitals at the time he was leaving the unit-by EMS equipment BP 197/88, R 18 P 63 O2 on room air 88-90%. This nurse attempted to reach family on the phone few times without success; .Pt alert and able to make his needs known at the time of his p/u at about 20:48, DON and ED were notified. Record Review of Resident #1's hospital records revealed the following: On 04/14/24 an MD noted the resident's CT scan results to have an age-indeterminate (timeframe not precisely determined or established) nondisplaced (broken bone not moved far enough during the break to be out of alignment) fracture at the right inferior pubic ramus (right pelvic fracture). The MD discussed resident remaining in the hospital for three days for observation. The resident preferred returning to the nursing facility for physical therapy and follow up with orthopedic surgery. The MD instructed the resident to provide the facility with pelvic fracture paperwork. Record Review of Resident #1's hospital discharge paperwork, revealed the following: On 04/14/24, the resident was diagnosed with a fall, scalp hematoma, multiple abrasions, and pelvic fracture. Record Review of Resident #1's clinical notes on 04/15/24, revealed: at 7:17 AM RN A wrote, DON was notified of pt's return and diagnosis from the ER visit. At 7:18 AM RN A wrote, Pt returned back from the hospital at about 0615 am, alert and able to make his needs known. The hospital reported diagnosis from the visit: Fall, scalp hematoma, multiple abrasions, pelvic fracture. NP notified. Vitals T 97.6 R 18 BP 150/70 O2 96% on room air. At 7 am he was given PRN pain med as per order for c/o pain on the head; endorsed to morning nurse. Further review of the treatment notes did not reveal, results of blood pressure, pulse, respiration, or temperature for Resident #1 on 04/15/24 at 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM by LVN B and 12:00 AM on 04/16/24 by LVN E. Treatment notes revealed equal hand grasps and normal motor function for Resident #1 recorded by LVN B on 04/15/23 at 8:00 AM, 12:00 PM, 8:00 PM and 12:00 AM by LVN E. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with LVN B on 04/16/2024 at 1:32 PM, She said she began working at the facility on December 11, 2023, as a Unit Manager. She said on 04/14/24 at 4:33 PM, she got a text from LVN A regarding Resident #1's unwitnessed fall. She said LVN A told her the resident had a knot on top of his right eye, and skin tear on his shoulder. She said she instructed LVN A to complete an SBAR and incident/accident report in Resident #1's electronic health record, call the DON and the resident's doctor. She said she has reviewed the SBAR, and the incident/accident report completed by LVN A in Resident #1's electronic health record. She said the LVN A carried out her directives and responded to the incident with Resident #1 appropriately. She said LVN A and LVN C helped Resident #1 get back into the bed after the fall. She said it was her expectation of any nurse to assess a resident before they moved them. She said once the nurse determined it was safe to move the resident, the nurse should help get the resident into a safe place, whether that is back into a chair or wheelchair, or back into bed. She said it was not necessary for her to do much follow up with her nurses, because her staff were astute. She said it was her expectation of a CNA that found a resident on the floor to press the call light, and if no one comes to follow up or assist, call for help down the hallway to get the resident some assistance. She said once the nurse arrived and assessed the resident, the CNA could help the nurse get the resident up and into a safe place. In an interview with LVN A on 04/16/24 at 1:53 PM, she said she had worked at the facility for a year. She said she was the charge nurse for 500 hall and was the nurse on duty when Resident #1 had an unwitnessed fall. She said one of the CNA's walked into Resident #1's room and found him on the floor. She said the CNA asked LVN A to come into the resident's room. She said assessed him and saw the resident had a hematoma on the top of his forehead, and a skin tear on his shoulder. She said Resident #1 said everything was fine, and did not complain of pain, but he had a head injury, so she gave him pain medication. She said the resident asked for pain medication once or twice a day and had a PRN pain medication. She said she cleaned the resident's wounds and put bandages on them. She said LVN C, from another hall, helped her get the resident back in the bed. She said when a resident had a fall, whether it was witnessed or unwitnessed, a nurse was supposed to do a head-to-toe assessment, pain assessment, and any first aid the resident needed . She said after they got the resident back into his bed, she put the bed in the lowest position, performed a fall risk assessment, pain assessment, completed an SBAR, notified the resident's nurse practitioner, DON, administrator, and the resident's responsible party. She said she documented the assessments and everything she did for the resident in his electronic health record. She said when she notified the nurse practitioner of Resident #1's fall, the nurse practitioner asked about the size of the resident's hematoma, and whether he was on blood thinners, or not. She said she told the nurse practitioner the resident was not prescribed a blood thinner but was prescribed aspirin. She said the nurse practitioner told to her Resident #1 needed to be monitored for changes and ordered neuro checks for 72 hours . She said the Resident was fine throughout the rest of her shift. She said Resident #1's change of condition did not happen on her shift, but she knew the resident was sent out to the hospital. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with CNA A on 04/16/24 at 2:32 PM, she said worked at the facility for four and a half years and worked with Resident #1 the three and a half years he had been living at the facility. She said the resident was very particular about the care he received from staff and would walk them through how he preferred to receive care. She said she was not the aide responsible for working on Resident #1's hall on 04/14/24. She said she walked over to the [NAME] unit to put out the schedules for the week when she heard yelling coming from a resident's room. She said LVN A, CNA B and CNA C were sitting at the nurse's station near where the yelling was coming from. She said she asked them who was yelling, and why. She said LVN A and CNA B told her Resident #1 was being demanding, yelling, screaming, and kicking at staff all day. She said she could not remember the exact time this occurred, but knew it was after lunch time. She said CNA B and LVN A told her they had already checked on the resident and that he was okay. She said she decided to go check on him because he was still yelling and screaming. She said she opened the door to the resident's room; she saw the resident on the floor next to his bed and saw blood on his forehead. She said she immediately went to go get LVN A from the nurse's station. She said once the nurse returned to Resident #1's room with her, the nurse got the resident into a sitting position on the floor. She said she was not sure what all LVN A did to assess the resident. She said the resident was not complaining about pain, but LVN A gave him pain medication. She said she did not stay with LVN A the whole time because she was not the aide responsible for the hall at that time and had other tasks to complete. She said she went back to the nurses station and told CNA B to go to Resident #1's room to assist LVN A. In an interview with CNA B on 04/14/24 at 2:49, she said she began working at the facility in January 2024, and had become a PRN staff as of 03/29/24. She said Resident #1 was very verbally aggressive towards women. She said Resident #1 called her stupid, ugly, and told her she had no class. She said the resident would also tell her to 'get the fuck out of his room.' She said she worked 9:00 AM to 6:00 PM on 04/14/24. She said there was another CNA, and LVN A sitting at the nurses station with her, when CNA A came and told LVN A Resident #1 was on the floor in his room. She said LVN A went to go check on Resident #1. She said she went to Resident #1's room also. She said she did not know exactly what LVN A did with Resident #1 as far as assessing him after his unwitnessed fall. She said she knew LVN A cleaned up the resident's wounds, gave him pain medication, and another nurse came and helped LVN A get the resident back into his bed. She said shortly after all of this she believed she left work for the day. In an interview with Resident #1 on 04/16/24 at 3:25 PM, he said he wasn't in the mood to be answering too many questions. He said before he fell , he was really upset, and wanted to go out into the hallway and get help. He said he did not know what he was thinking. He said he was trying to get out of his bed and into his wheelchair. He said he sat up and was sitting on his bed and the next thing, he was on the floor. He said he did not press his call light before he tried to get out of bed. He said he was just so mad, he did not think about it. He said he was just upset and wanted to talk to the nurse. He said his wheelchair was in the same spot it is currently in (about five feet away from the end of his bed, against the wall), when he fell . He said he just could not get off the floor on his own. He said now he had a whole new set of health issues and injuries to worry about. He said he was getting upset all over again. He said he no longer wanted to speak about the incident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with LVN D on 04/16/24 at 4:38 PM , she said she was familiar and had worked with Resident #1 before. She said if she had found or been notified to respond to Resident #1 being found on the floor, she would have assessed the resident first. She said she would do a visual assessment for visible injuries, make note of their size, color, amount of bleeding, etc. She said Resident #1 was alert and oriented times three, so she would have asked him about the locations of his pain, if he had any pain at all, and level of pain using the 0-10 scale. She said she would assess the resident's range of motion by having him flex his lower extremities and instructing him to grab onto her arm with his hands. She said she would check his pupils, temperature, blood pressure, pulse, and any other necessary vital sign. She said everything she observed and everything she did with the resident would be documented on an SBAR, Pain Assessment, Fall Assessment, Incident Report, and clinical notes in the resident's electronic health record. She said she would also make notifications to the doctor, DON, Administrator, and the responsible party; and document the attempts in the resident's electronic health record. She said a nurse was supposed to use their best judgment in the moment to prevent injury to the patient, but also to prevent injury to themselves. She said Resident #1 was a bigger buy, and if she assessed him after a fall, witnessed or unwitnessed, and determined it was safe to move him, she would have gotten another nurse to assist her in using a mechanical lift to get him off the floor and back into his bed. She said she would begin closely monitoring the resident for changes, follow any orders given by the physician and start neuro-checks on the resident every 15 minutes, 30 minutes, 1 hour, 2 hours, etc. for the necessary 72-hour period. She said if she was the nurse to respond to any resident who suffered an unwitnessed fall and had any sort of head injury, she would err on the side of caution and call 911. In an interview with LVN C on 4/17/24 at 9:57 AM, she said on she worked on 04/14/24, the day Resident #1 had an unwitnessed fall. She said she was coming out of room [ROOM NUMBER], LVN A was coming out of Resident #1's room and were both headed towards the nurse's station. She said LVN A asked her to help get Resident #1 off the floor in his room. She said when they went back to the resident's room, LVN A was carrying a blood pressure cuff. She said she was not sure whether LVN A had completed her assessment on Resident #1 at that point. She said when she went into the room, the resident was on the floor sitting straight up, with his legs sort of crossed. She said she did not observe any blood or active bleeding on the resident. She said the resident had a bandage on his head. She said the resident never complained about pain. She said LVN A asked Resident #1 if he was in pain before they got him up off the floor, and after they got him back into his bed. She said both times Resident #1 said he was fine. She said once they got Resident #1 back into his bed, LVN A helped her with the resident while she put briefs back on the resident. She said when Resident #1 went to turn over to the right, on the left side of his body, he could not do that on his own, so LVN A helped her turn him during putting on the briefs. She said she was not sure whether the resident being able to turn on his side was a baseline behavior for him or not. She said after they put the briefs on, the resident asked to be adjusted and scooted down in his bed. She said she asked LVN A if she needed anything else, and LVN A said no. She said she went back to working on things for her residents, LVN A stayed behind and was in Resident #1's room a little bit longer. She said she knew LVN A notified Resident #1's doctor because she heard LVN A read the message from the provider out loud, which said to monitor the resident and send him out if he had any changes in condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the DON on 04/17/24 at 10:45 AM, he said he had worked at the facility for four months. He said based on what he reviewed regarding the incident with Resident #1, the care Resident #1 received from staff after his unwitnessed fall was appropriate. He said if a CNA found a resident on the floor, it was his expectation for the CNA to call out for help. He said the aide could press the call light, or yell for help, but the CNA was supposed to stay with the resident until the nurse arrived to give directives. He said once the nurse arrived, the nurse was supposed to begin doing assessments and observations on the resident. He said for any fall, a nurse needed to do a visual assessment to look for obvious injuries and a head-to-toe assessment. He said a head-to-toe assessment consisted of checking neuro status by checking the patient's pupils, having them perform hand grips with the nurse and looking for any slurred speech . He said the nurse needed to identify any head trauma; look to see if the resident was on an anticoagulant or aspirin; check for abrasions and any obvious deformities on the body; and assess the resident's pain. He said a pain assessment should be done using the 0-10 scale unless the resident was could not verbalize discomfort. He said then, the nurse needed to look for signs of pain from the resident, like grimacing of the face. He said the nurse would need to notify the physician and treat the resident according to the physician's orders. He said if a resident had a head injury after any fall, they would call 911 and the resident would be sent out to the hospital. He said that nurses were also trained to use their best judgement. He said LVN A performed her assessments, spoke with the resident and the resident's doctor and the doctor gave an order to monitor the resident and send him out to the hospital if there were any changes in condition. He said the resident experienced a change in condition when he complained of pain on the next nurse's shift, the physician was notified, and the resident was sent to the hospital. He said, according to the inservices he conducted with staff yesterday, a resident who suffered a fall, had a visible fracture, or was expressing pain was not supposed to be moved by staff, instead call 911 and notify the physician. He said yesterday, the entire staff was inserviced on fall management. He said Resident #1 never complained about pain during his assessments with LVN A. He said staff were also doing extra rounding on Resident #1 to make sure he was not in any pain. He said he reviewed all the documentation completed by LVN A on 04/14/24, and she did everything right. He said he was not sure if he saw any documentation completed by LVN A regarding assessing Resident #'1 range of motion. He said he did not ask LVN A whether she assessed the resident's range of motion before moving him, but he was sure LVN A assessed his range of motion. He said if LVN A performed range of motion on the resident at the time of her assessment, it would have been documented in the clinical notes with the rest of the information assessed by the nurse. He said when documenting range of motion, the nurse needed to describe whether the resident had full or limited range of motion and the location on the resident's body. He said he would have to review the resident's electronic health record to see what LVN A documented for Resident #1's range of motion. He said he reviewed LVN A's documentation and agreed she did not document Resident #1's range of motion after his unwitnessed fall. He said not performing or not documenting a resident's range of motion could put a resident at risk of further injury or not receiving the appropriate care. Record Review of Inservice, dated 04/17/24, revealed the following: The inservice did not reveal moving residents after a fall with a head injury as a topic of discussion. All staff from all departments were trained by the administrator about falls, in that; any staff that finds a resident that has a fall, witnessed or unwitnessed, will remain with the resident until a nurse arrives to assess and give directives. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the Regional Director of Clinical Services and the Administrator on 04/19/24 at 8:55 AM, The Regional Director of Clinical Services said if a CNA or Medication Aide found a resident on the floor, they were not to touch the resident until an assessment had been completed by nurse. She said finding a resident on the floor or any other medical emergency, could have been a case-by-case scenario where staff would have to use their best judgement to get the resident the help they needed. She said sometimes, pressing the call light or calling out for help may not get help for the resident quick enough. She said the staff may have to stick their head out in the hall and yell for help. She said it was not acceptable for any staff to leave a resident with obvious injuries, especially to the head, or after an unwitnessed fall. She said however, if the staff had yelled for help to the best of their ability, and no one responded they may have to physically step away from the resident to alert the nearest staff. She said if any resident had a fall and complained of pain to the head, the resident would be sent out to the hospital. She said a resident who had an unwitnessed fall might need to be evaluated on a different level. She said the nurses used their best judgement, but ultimately the results of the nurse's neuro assessment determined whether a resident who suffered an unwitnessed fall needed to be sent to the hospital. She said her expectations of an assessment completed by a nurse after a resident had an unwitnessed fall included checking vitals (such as, blood pressure, heart rate, temperature, and respiration) checking pupils, asking the resident if they were experiencing pain. She said the resident was not able to verbalize pain, look for grimacing and wincing. She said as far as pain assessment, the nurses should have used the pain scale and documented the numerical representation of the pain level on the incident/accident report and the resident's TAR. She said nurses were also supposed to document the location of the pain. She said as far as range of motion, the nurse needed to document whether the resident had full or limited range of motion. She said for the nurse to assess range of motion they needed to slowly move all extremities and look for resident responses to those movements. She said the nurse could also do slow movements of the pelvis to assess range of motion. She said range of motion should be documented whether the resident's fall was witnessed or unwitnessed. The Clinical Director and the Administrator agreed they were unsure as to whether LVN A assessed Resident #1's range of motion after his unwitnessed fall. The administrator agreed LVN A did not document the resident's range of motion. The Clinical Director said once a nurse decided it was safe to move a resident after a fall, they needed to get assistance from at least one other staff to get the resident off the floor. She said the nurses needed to use their best judgement and help the resident with a two-person assist, a mechanical lift, or even placing a sheet underneath the resident to get them up. The Administrator said from what he read, there were improvements the nurses and the rest of the staff could make in responding to and documenting a resident incident. He said this incident highlighted that while the nurses know what to do in the moment, they were not documenting the necessary details. Record Review of Inservice, dated 04/19/24, revealed the following: All staff from all departments were trained by the administrator on the subject of falls, in that; any staff that finds a resident that has a fall, witnessed or unwitnessed, will remain with the resident until a nurse arrives to assess and give directives; and, an RN or LVN must document vital signs, neuro checks, pain using the 0-10 pain scale, range of motion, skin integrity (bruising, cuts, lacerations, hematomas, abrasions), resident interview as part of a head to toe assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676357	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Broadmoor at Creekside Park	5665 Creekside Forest Drive The Woodlands, TX 77389

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the policy, dated November 2022, titled, Fall Management Guidelines revealed the following: 1. Definition: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface .Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .3. Complete the Intervention Checklist for Patient .6. When the Patient experiences a fall: Licensed nurse will assess the Patient. Before moving the patient, check for injury. Stabilize the Patient and provide immediate treatment if necessary. If the Patient has a serious injury, do not move the Patient. Inform the Physician, Responsible Party and call 911 for ambulance. Obtain vital signs (Temperature, Pulse, Respiration, Blood Pressure). A Head-to-Toe Assessment will be performed at the time of the fall .Document a clinical note in the electronic health record .The DON and/or Unit /Manager will ensure the Intervention Checklist, Fall Risk Care Plan and Daily Care Guide were updated as needed. Record review of the policy, revised January 2024, titled, Follow-Up for Potential Head Injury revealed the following: Responsibility Licensed Nurse Purpose To observe, record and report any condition change to the attending physician so proper treatment will be implemented .Procedure Following any head trauma, monitor the following: Observe for lacerations; if present, clean apply dry, sterile dressing. Note size, depth, and amount of bleeding or drainage. Observe for swelling and discoloration; if present, chart size, site, amount and color .Observe and inquire if patient has headache or pain .Observe for sensory weakness. Observe for generalized weakness .Observe for proper reflexes .Have someone stay with the patient while the charge nurse notifies the physician on call .Complete an incident/accident report if applicable .Documentation Date, time condition change was identified .Emergency care provided . Record review of the policy, dated November 2015, titled, Change in a Resident's Condition or Status revealed the following: 2. A significant change of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting); b. Impacts more than one area of the resident's health status; and, d. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii) .3. Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the SBAR (Interact Version 4.0) Communication Form. Policy Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the r[TRUNCATED]