STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676394	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Place Rehabilitation Suites	5600 Woodlands Trail Denison, TX 75020

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority the resident representative when there was a a significant change in the resident's physical status for one of six residents (Resident #1) reviewed for change of condition. ADON A failed to read Resident #1's x-ray results received at the facility on 01/18/24 and failed to notify/consult the Physician about the resident's femur (thigh bone) fracture and change of condition using the facility's approved notification methods leaving Resident #1 with an undiagnosed /untreated fracture for 29 days (01/18/24 to 02/13/24). Resident #1 fell on [DATE] at 03:15 a.m. with no apparent injury, but when attempting to get up, the resident's legs kept giving way. Resident #1 was transported to the hospital and returned to the facility on [DATE] with no known fractures. On 01/15/24 Resident #1 complained of excruciating pain to her left leg and reported having an additional fall to PT R and the DOR/OT during their assessments. An X-ray was completed on 01/15/24 which was negative. On 01/18/24 another X-ray was obtained which showed a left intertrochanteric femoral fracture (type of hip fracture). The physician or family were never notified. Resident #1 was transferred to Facility X on 02/05/24 due to needing a Medicaid pending bed. Resident #1 continued to receive physical therapy at Facility X. On 02/13/24 Resident #1 was sent to the hospital due to continued hip pain and an X-ray confirmed a left hip fracture. Resident #1 received surgery to repair the hip fracture on 02/15/24, 29 days after the initial X-ray which showed the fracture. An Immediate Jeopardy (IJ) was identified on 04/16/24 at 04:45 p.m. The IJ template was provided to the facility on [DATE] at 05:02 p.m. and signed by the Administrator. While the IJ was removed on 04/18/24 at 01:15 p.m. the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. These failures placed residents at risk of a delay in medical treatment which could lead to worsening of their condition, hospitalization , and/or death. Findings include: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's 5-day MDS assessment, dated 01/20/24, reflected a [AGE] year-old female admitted to the facility on [DATE] and a re-admission on 01/14/24. Resident #1 had a BIMS of 12 which indicated her cognition was moderately impaired. Resident #1 required partial to substantial assistance with ADLs. Her diagnoses included coronary artery disease, myocardial infarction (heart attack), COVID-19, and unspecified fall. The assessment indicated the resident had zero fall since re-admission and had no pain. She had received PT and OT services with a start date of 01/15/24. Record review of Resident #1's base line care plan dated 01/09/24, reflected, Resident is a new admission . post cardiac stents and COVID positive .Goals .Resident's immediate health and safety needs will be identified .Approach .Fall Risk .Minimize falls .Encourage use of call eight .Pain Management .Monitor Pain . Verbal/descriptor .Location .General Treatment-see Physician orders . Record review of Resident #1's PT evaluation and Plan of treatment completed by PT R, dated 01/15/24 reflected, .Patient subsequently was originally admitted to the [facility] on 1/09/24 in order to participate with rehab. However, she had experienced a backward fall after her admittance hitting her posterior (back) aspect of the head on the floor. She was returned to [Hospital name] for evaluation on 1/10/24. Following all of the routine tests at the hospital patient was diagnosed with NSTEMI (type of partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart). She was treated and eventually deemed clinically stabilized sufficiently to be returned to the [Facility] on 1/14/24 to resume her rehab. On the morning of 1/15/24 patient apparently transferred herself from the bed and possibly was attempting to walk toward the bathroom when she lost her balance and experienced another fall. There was ensuing pain in the left hip and along the full length of the lateral (outside) left femur prompting the order for a X-ray of the LLE (left lower extremity). The results were NEG(-) for showing any acute fracture or dislocation. However, patient is experiencing significant pain in the left hip which radiates along the tensor fascia [NAME] (muscle located in the upper outer thigh and hip) in distally to the lateral (outside) left knee. The pain is intense and increases with any attempt to move the left LE actively or passively from the current angulation (angle) described as left hip flexion (pulling the knee close to the chest), excessive across-midline adduction (brining the hip towards the midline of the body), and internal rotation (happens when you twist your thigh inward from your hip joint). Pt's therapy will be addressing her declines in mobility and performance of ADLs due to her decreases in endurance, strength, and balance for upright positioning .History of Falls .The most recent fall on the morning of 01/15/24 resulting in strains/contusion to the lateral left hip/thigh/knee causing pain and challenges for movement (whether active or passive) for left hip. Attempts to passive move the left leg is met with protective guarding and resistance .Pain assessment .Pain at rest-4/10 (scale used where 0 is no pain 10 is most severe pain); frequency-constant, daily, location-left hip, Description-gnawing, heavy, throbbing, dull ache and burning .Pain with movement-9/10-Frequency- Daily, intermittent- location- Left hip/thigh/knee laterally. Pain description-Burning, aching, cramping and sharp, quick . Record review of Resident #1's OT evaluation and plan of treatment completed by the DOR, dated 01/15/24 reflected, .Once admitted , patient had a fall and was sent back out to hospital and was dx (diagnosed) with NSTEMI. She has returned to this facility with therapy eval orders in place. She has already had another fall at this facility, c/o L hip pain, and was ordered Xray, which was negative for fracture. Upon eval, pt was unable to straighten LE, and remained in severe IR (internal rotation) to L hip. Nursing notified, and patient was assisted for improved positioning of LLE. She still complains 9/10 pain to L hip .Pain Assessment-Patient verbalized pain level .Paint at rest-4/10 .Pain with movement .9/10 .What relieves pain .sitting down, remaining still .What exacerbates pain .sitting, standing, bending, prolonged activity . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's falls summary report from 01/14/24 through 04/15/24 did not indicate a fall for Resident #1 on 01/14/24 or 01/15/24. Record Review of Resident #1's physician's orders for January 2024 did not reflect an order for X-ray for 01/15/24 or 01/18/24. Resident #1 did have Tramadol 50 mg 1 tablet every 6 hours as needed for pain with a start date of 01/14/24. Record review of Resident #1's Narcotic disposition form dated 01/18/24 for Tramadol 50 mg 1 tab every 6 hours as needed for pain, reflected the resident was treated for pain on 01/18/24, 01/19/24, 01/20/24, 01/21/24, 01/22/24 (2x), 01/24/24, 01/25/24 (2x), 01/26/24, 01/27/24, 01/28/24 (2x), 01/29/24, 01/30/24(2x), 01/31/24, 02/01/24, 02/02/24, 02/03/24 (2x), and 02/04/24. Record review of Resident #1's TAR from 01/14/24 through 02/04/24 reflected, Every shift check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale mild, moderate, severe, very severe. Shift 1 from 01/14/24 through 02/04/24 indicated no pain. Shift 2 indicated- no pain from 01/14/24-01/17/24, 01/18/24-01/20/21- moderate pain, 01/21/24- no pain, 01/22/24-moderate, 01/23/24-no pain, 01/24/24- moderate pain, 01/25/24- no pain, 01/26/24-01/28/24-moderate pain, 01/29/24-no pain, 01/30/24-02/01/24 moderate pain, 02/02/24-02/04/24- no pain. Record review of the Radiology report dated 01/18/24 completed at 02:41 p.m. reflected, Conclusion: Interval increase in angulation (alteration of aliment) of the intertrochanteric left femoral (type of thigh bone fracture) fracture as noted. Compare with 01/15/24. Record review of the e-mail provided to the facility from the contracted radiology company on 04/17/24 reflected the following timeline: X-ray Ordered: 01/18/24 at 01:04 p.m.- completed on 01/18/24 at 02:20 p.m. Resulted on 01/18/24 at 02:41 p.m. Faxed to the facility on [DATE] at 02:45 p.m. Unsuccessful attempts called to facility at 01/18/24 at 04:59 p.m. and 05:47 p.m. Record review of Resident #1's NP's note dated 01/18/24 at 01:01 p.m. reflected, .Seen today without issues or concerns .Status post fall. No reports of syncope (dizziness). CT of the brain was negative. Fall precautions .plan of care reviewed and discussed with [MD] . Record review of the facility's 24-hour report for 01/18/24 and 01/19/24 did not reflect any follow up for the X-Ray result and indicated no change in Resident #1. Record review of Resident #1's Nurse Progress notes and daily observation note for 01/18/24 did not indicate an order was received to repeat Resident #1's X-ray. No indication of pain or complaints. Record review of Resident #1's hospital record dated 02/13/24 reflected, admitted to [Facility X] on 02/05/24 from [Facility Y] with left hip pain. Patient requested repeat X-ray today due to pain not getting any better. X-Ray showing left femoral neck fracture. Alert and oriented x 4, incontinent due to pain. Surgical repair of her left hip fracture was completed on 02/14/24. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN F on 04/16/24 at 10:15 p.m. she stated she worked the 06:00 a.m. to 06:00 p.m. shift. She stated she worked on 01/14/24 when Resident #1 was readmitted to the facility. She stated she did not recall her having any additional falls on her return to the facility. She stated she was off from 01/15/24 through 01/27/28. She stated the process when they received an order for an x-ray was to place the order in the resident's electronic record, place the order in the radiology request portal, place it on the 24-hour report and make a note in the progress note of the pending request and any assessment needed that resulted in the request. She stated once the results were received, they were to notify the family and MD and document in the progress note the notification was completed and sign off on the X-ray result and place it in the MD's box for their review. LVN F searched Resident #1's electronic record and stated there were no X-Ray results uploaded into the record. She stated the progress note dated 01/15/24 reflected an X-ray had been completed and was negative. LVN F searched the radiology portal and stated there were copies of the X-ray results for 01/15/24 and stated there was another report for 01/18/24. She stated the X-ray request for 01/18/24 was put into the system by ADON A. She stated the X-ray for 01/18/24 showed a fracture. She stated she was unaware the resident had a fracture. She stated that surprised her since the resident had not complained of pain to her. She stated the X-ray company would fax the results but would also call if the X-ray was positive for a fracture. In an interview with PTA S on 04/16/24 at 10:30 a.m. he stated Resident #1 had expressed to PT R during his assessment she had fallen again, but stated there was some confusion if she had fallen on the re-admission or if it was the fall, she had on her first admission on 01/09/24. He stated she was expressing pain the first day of therapy on 01/15/24, but after that she did not complain and was progressing slowly with therapy. He stated he knew the X-ray on 01/15/24 was negative for a fracture, so they proceeded forward with therapy. He stated he was unaware of the X-Ray completed on 01/18/24 and was shocked she had a fracture. In an interview with the NP on 04/16/24 at 10:40 p.m. she stated she vaguely remembered Resident #1. She stated she saw the resident 3 x week during her stay at the facility and she did not recall her ever complaining to her about pain in her hip. She stated she did not recall ordering an X-ray for the resident on 01/15/24 or 01/18/24. She stated she would usually place anything like that in her notes to ensure she followed up. She stated the nurse's may have mentioned it to her in passing and she gave a verbal OK for the X-Ray. She stated the facility would call her or the MD with the results of the X-ray and they placed a copy of the report in the MD's communication box for her and the MD to review. She stated she did not ever see an X-ray that showed a fracture to the resident's femur. She stated if she had seen it they would have sent her out to the hospital for further evaluation and treatment immediately. In an interview with ADON A on 04/16/24 at 11:30 a.m. she stated she was covering for the DON on the week of 01/15/24. She stated it was a crazy week, stating she had family who were also in the hospital during that time. She stated in addition they were using a lot of agency nurses. She stated she did not recall what prompted her to request the X-ray on 01/18/24 for Resident #1. She stated she did not recall being notified from PT or OT that Resident #1 had reported another fall on 01/15/24. She stated she should have placed an order in the resident's chart for the X-ray on 01/18/24 and should have placed it on the 24-hour report for follow up. She stated the nursing staff should have documented in the progress notes any complaints of pain the resident had and if PT had indicated a fall, and an incident report should have been completed. She stated she was unsure how the X-ray report was never reviewed by nursing or the physician. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempted to reach Agency LVN O on 04/16/24 at 12:14 p.m. by phone. No answer. Agency LVN O worked at the facility on 01/18/24 and was assigned to Resident #1's hall. In an interview with Facility X's DON on 04/16/24 at 12:20 p.m. she stated Resident #1 transferred to their facility on 02/05/24. She stated the resident had received therapy since her admission to their facility. She stated on 02/13/24 the resident requested a repeat X-ray of her left hip because she did not think Facility Y's X-rays were done correctly, since her left hip had continued to hurt. She stated they ordered an X-ray, which showed a left femur fracture. She stated the resident was sent to the hospital 02/13/24 and underwent surgical repair to her left hip. She stated the resident had since returned to the facility and was doing well. In an interview with PT R on 04/16/24 at 12:20 p.m. he stated he had reported to nursing on 01/15/24 about the resident's complaints of pain to her left hip, which was why an X-ray was ordered. He stated he did not recall if he reported to them about the resident's comments about falling that morning. He stated the X-Ray on 01/15/24 was negative, so they proceeded with therapy, but stated if a resident presented with symptoms or discomfort, they would back off therapy. He stated the resident did not present as someone with a hip fracture and was able to stand and ambulate for short distances. He stated it was not uncommon for a new admission to have more pain at first because they were sometimes waiting for the resident's pain medication to arrive. He stated the resident did not complain of pain after the first initial day and was making some progress in her therapy. He stated they will frequently ask nursing to request an X-ray if they have concerns about a possible fracture, but stated he did not request a second X-ray on 01/18/24. In an interview with the MD on 01/18/24 at 12:40 p.m. he stated he did not recall any calls from the facility regarding the results of an X-ray which showed a femur fracture for Resident #1. He stated had he been notified he would have sent her to the hospital immediately for treatment. He stated they would repeat an X-Ray if a resident continued to complain of pain and the initial X-ray was negative to make sure there was not a fracture. He stated the NP was in the facility three times a week and would update him of any changes in his patients. He stated he did not know why the radiology company did not contact him directly when they were unable to reach the facility. He stated an untreated fracture could result in death, increased pain, bleeding, and blood clots. In an interview with the DON on 04/16/24 at 1:10 p.m. she stated she was on family medical leave during the week of 01/15/24 and ADON A was covering for her. She stated she had not been able to locate any incident report of a fall for Resident #1 since her readmission on 01/14/24. She stated agency staff do not have access to the radiology portal so a facility staff member would had to have put in the request for any X-ray. She stated the facility staff should ensure the X-ray order was placed in the electronic record and placed on the 24-hour report for follow up. She stated the agency staff were oriented to the electronic record and were provided access. She stated they should document any assessment of pain or notification to the family and physician. She stated she suspected when the fax copy of the X-ray report came in it was placed in the box to be scanned instead of the MD's box for review and when the Medical Records clerk picked up the reports, she did not notice it had not been reviewed by the physician or nursing. She stated she would be doing education with the Medical Records clerk to ensure those reports were placed back into the MD's box to ensure proper review. She stated the failure started with ADON A when she did not ensure an order was placed in the electronic record, a progress note notifying the family of the requested X-Ray and failing to place it on the 24-hour report. She stated had the ADON followed up even with the misplacement of the report, they would have been aware of the results of the X-Ray. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with Resident #1 on 04/16/24 at 1:50 p.m. she stated she was finally on the road to recovery. She stated she remembered very little about her stay at Facility Y. She stated she did not recall falling and was not sure if she fell more than once. She stated she did not know if she was having a lot of pain. She stated she remembered in February 2024 having pain in her left hip when she moved a certain way. She stated she just remembered her stay at Facility Y was not pleasant. She stated since she had her hip repaired, she was walking with a walker and getting much stronger. In an interview with Agency LVN P on 04/16/24 at 3:10 p.m. she stated she worked at the facility on 01/15/24, 01/16/24 and 01/17/24. She stated she did recall Resident #1 and remembered the physician had requested an X-ray on 01/15/24 due to hip pain. She stated she did not recall being told she had fallen. She stated she remembered Resident #1's family was with her most of the time, and would ask for pain medication for her, but stated when she assessed her for pain the resident would deny being in pain. She stated if she got an order for an X-ray, she would have to get one of the facility staff to place the request in the portal since she did not have access. She stated she would place the information about the X-ray on the 24-hour report and any notifications she made in the progress notes. Attempted to contact Agency LVN M on 04/16/24 at 4:22 p.m. who worked on 01/18/24. Unable to leave a message-voice mail was full. Record review of the facility policy titled Laboratory Testing, revised May 2023 reflected . Requests for diagnostic services must be ordered by the patient/resident's attending physician or physician extender . Orders for diagnostic services must be entered into the resident's medical record and signed by the attending physician or physician extender .Results of laboratory, radiological, and diagnostic tests shell be reported in writing to the resident's attending physician or physician extender or to the facility via fax or electronic reporting .The attending physician or physician extender shall be promptly notified of abnormal, critical, or stat test results. The charge nurse receiving the test results shall be responsible for notify the physician or physician extender of such test results in a timely manner . Record review of the facility's policy, Physician and other communication/change in condition revised May 2023, revealed To improve communication between physician and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decision regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/resident's and their responsible party regarding change in condition .Complete assessment of the patient/resident which may include but is not limited to .Patient's/resident's previous condition .Recent labs, x-ray results .Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's/resident's condition in the medical record .The patient/resident and patient's /resident's family member/legal representative will be notified of any changes in medical condition or treatment plan . The Administrator was notified on 04/16/24 at 05:02 p.m. that an Immediate Jeopardy situation had been identified due to the above failures. The IJ template was provided at this time and plan of removal was requested. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Requests for diagnostic services must be ordered by the resident's physician. Orders for diagnostic services will be promptly carried out as directed in the physician's order. Shift to shift report will be given to oncoming nurse for effective communication regarding resident care and treatment, including changes of condition, new orders, incidents/accidents and follow up for diagnostic services. Licensed Nurses will be reeducated on 4/17/24 by the Director of Nursing/Designee on change of condition including: Residents showing signs of a change of condition will be assessed to appropriately identify and document the acute change in condition and notify the physician for further direction. Assessment may include but not limited to a. Residents physical condition b. Residents previous condition c. Vital signs, including pain. d. Recent labs, x-rays e. Previous and current mental status f. Medications g. Resident wishes h. Any interventions provided to the resident. Licensed Nurse will notify responsible party of residents change in condition. Any licensed nurse not receiving this education by 4/17/24 will receive prior to their next scheduled shift. This will be presented in new hire and agency orientation. The next 6 shift changes a member of nursing management (Nurse Assessment Coordinator, RN Supervisor, Director of Nursing, Assistant Director of Nursing) will attend shift to shift report to validate that any resident that has had a change of condition has been assessed appropriately, physician notified, and orders implemented promptly, and responsible party notified. The Director of Nursing/Designee and/or Manager on Duty will review the 24-hour report and the facility activity report to identify any documentation regarding a change of condition, including falls, and validate that the resident has been assessed appropriately, physician notified, RP/Family notified, and orders implemented promptly. This includes diagnostic testing and results. This will be completed Monday -Friday in the Clinical Meeting and Charge Nurse on weekends. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility Medical Director will be notified of the Immediate Jeopardy and the contents of this plan on 4/16/24 and will be given progress updates. Monitoring The facility's implementation of the IJ Plan of Removal was verified through the following: Record review of the facility's Summary Utilization Report dated 01/01/24 through 04/16/24 reflected a 100% audit of all radiology requests made had been reviewed and verified physician notification was made on all request except for Resident #1 on 01/18/24. Record review of the Shift-to-Shift verification report reflected on 04/16/24 the DON participated in the 6 p.m. to 6 a.m. shift report and ADON B participated in the shift-to-shift report for the 6 a.m. to 6 p.m. shift changes. Record review of facility's in-service initiated on 04/16/24 by the Clinical Service Director reflected the DON was in-serviced on the facility's policy on Abuse and Neglect, fall management and assessment of the resident post fall, significant changes of condition and the facility's lab and radiology procedure for notification to physician. In an interview with the DON on 04/18/24 at 9:30 a.m. she stated the root cause of the failure was the ADON's failure to follow procedure and failure to follow up. She stated it was her expectation for any nurse who received an order due to a change of condition to follow up on the resident, notify the physician and family. She stated staff must report from shift to shift when there had been a change so ongoing follow up could continue. She stated she monitored for that by making daily rounds, following up after daily stand-up meetings and review of the 24-hour report. She stated going forward therapy had been instructed to notify her as well as the nursing staff on any changes in a resident's condition so she will be assured required follow up is completed. Record review of the facility's in-service initiated on 04/16/24 by the Clinical Service Director reflected the Administrator was in-serviced on the facility policy for abuse and neglect. In an interview with the MD on 04/18/24 at 10:54 a.m. he verified he had reviewed the facilities Plan of removal and stated he had reviewed with his NP his expectation for follow up on any their residents for X-ray results. In an interview with the Administrator on 04/18/24 at 11:14 a.m. he stated he had been re-educated on abuse and neglect on 04/16/24. He stated he had self-reported the allegation of neglect involving Resident #1 and they had suspended ADON A until the completed investigation. He stated he felt the failure of the ADON resulted in neglect related to the failure to follow up on the X-ray which resulted in the physician never becoming aware of the results and the resident not receiving necessary treatment. He stated it was an unfortunate time since he was also off during that time frame as well. He stated he made daily rounds especially on the rehab hall, so residents knew who to report any concerns to. He stated he had reached out to Resident #1's responsible party on 04/17/24 to inform them of the X-ray results and to let them know they were taking the failure very seriously and doing everything possible to ensure this never occurred again. (continued on next page)

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	676394	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Place Rehabilitation Suites	5600 Woodlands Trail Denison, TX 75020

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of the facility's Inservice Records dated 04/17/24 reflected staff were educated on Fall management, Abuse and neglect, signification changes in condition, physician notification and verification of Radiology request. Interviews conducted on 04/17/27 from 3:30 p.m. to 4:00 p.m. with 2nd shift charge nurses RN E and RN C revealed they had received in-service training and were able to verbalize understanding of the in-service training regarding x-rays to be completed in timely manner and to follow up to physician and responsible party. They were knowledgeable of the documentation process for placing the orders in the electronic record, notation on the X-ray results of their review and notification to the physician. The were aware of the fall and incident reporting criteria and communication to oncoming shifts of any changes through the 24-hour report. They were all knowledgeable of abuse/neglect policy on reporting, neglect definition including a delay in treatment and to report any allegations immediately. Interviews conducted on 04/18/24 from 08:34 a.m. to 10:05 a.m. with 1st and 2 shift staff, LVN H, LVN I, LVN F, LVN J, LVN K, and LVN G revealed they had received in-service training and were able to verbalize understanding of the in-service training regarding x-rays to be completed in timely manner and to follow up to physician and responsible party. They were knowledgeable of the documentation process for placing the orders in the electronic record, notation on the X-ray results of their review and notification to the physician. They were aware of the fall and incident reporting criteria and communication to oncoming shifts of any changes through the 24-hour report. They were all knowledgeable of abuse/neglect policy on reporting, neglect definition including a delay in treatment and to report any allegations immediately. Interviews conducted on 04/18/24 from 10:10 a.m. to 10:40 a.m. with therapy staff COTA Q, PT R, PTA S, PTA T, and COTA W revealed they had received in-service training on fall management which included the reporting to the DON as well as nursing staff any self-reported fall from a resident, and any change in condition related to pain and inability to bear weight. The sta [TRUNCATED]

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interviews and record reviews, the facility failed to ensure the resident has the right to be free from neglect for one of six residents(Resident #1) reviewed for neglect. 1. ADON A failed to follow the facility's process for documentation, transcription and notifications when she failed to transcribe the physician's order on 01/18/24 for an X-ray request for Resident #1's left femur (thigh bone), failed to document an assessment of Resident #1's pain to determine the location, duration, and scale of Resident #1's pain, failed to place the X-ray request for 01/18/24 on the 24-hour report for follow-up, and failed to notify the responsible party of the X-ray request and results. 2. The facility staff failed to follow the facility's process for communication, both verbal and in writing, to the physician, X-ray results obtained on 01/18/24 which identified a left femoral fracture for Resident #1. 3. The facility staff failed to follow the facility's process for investigating Resident #1's complaint of an additional fall and pain on 01/15/24. Resident #1 fell on [DATE] at 03:15 a.m. with no apparent injury, but when attempting to get up, the resident's legs kept giving way. Resident #1 transported to the hospital and returned to the facility on [DATE] with no known fractures. On 01/15/24 Resident #1 complained of excruciating pain to her left leg and reported having an additional fall to PT R and the DOR/OT during their assessments. An X-ray was completed on 01/15/24 which was negative. On 01/18/24 another X-ray was obtained which showed a left intertrochanteric femoral fracture (type of hip fracture). The physician or family were never notified. Resident #1 was transferred to Facility X on 02/05/24 due to needing a Medicaid pending bed. Resident #1 continued to receive physical therapy at Facility X. On 02/13/24 Resident #1 was sent to the hospital due to continued hip pain and an X-ray confirmed a left hip fracture. Resident #1 received surgery to repair the hip fracture on 02/15/24, 29 days after the initial X-ray which showed the fracture. An Immediate Jeopardy (IJ) was identified on 04/16/24 at 04:45 p.m. The IJ template was provided to the facility on [DATE] at 05:02 p.m. and signed by the Administrator. While the IJ was removed on 04/18/24 at 01:15 p.m. the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. These failures resulted in delayed medical treatment, ongoing pain, delay in rehabilitation, hospitalization and placed the resident at risk of death, bleeding, and increased severity of the initial fracture. Findings include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's 5-day MDS assessment, dated 01/20/24, reflected a [AGE] year-old female admitted to the facility on [DATE] and a re-admission on 01/14/24. Resident #1 had a BIMS of 12 which indicated her cognition was moderately impaired. Resident #1 required partial to substantial assistance with ADLs. Her diagnoses included coronary artery disease, myocardial infarction (heart attack), COVID-19, and unspecified fall. The assessment indicated the resident had zero fall since re-admission and had no pain. She had received PT and OT services with a start date of 01/15/24. Record review of Resident #1's base line care plan dated 01/09/24, reflected, Resident is a new admission . post cardiac stents and COVID positive .Goals .Resident's immediate health and safety needs will be identified .Approach .Fall Risk .Minimize falls .Encourage use of call eight .Pain Management .Monitor Pain . Verbal/descriptor .Location .General Treatment-see Physician orders . Record review of Resident #1's PT evaluation and Plan of treatment completed by PT R, dated 01/15/24 reflected, .Patient subsequently was originally admitted to the [facility] on 1/09/24 in order to participate with rehab. However, she had experienced a backward fall after her admittance hitting her posterior (back) aspect of the head on the floor. She was returned to [Hospital name] for evaluation on 1/10/24. Following all of the routine tests at the hospital patient was diagnosed with NSTEMI (type of partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart). She was treated and eventually deemed clinically stabilized sufficiently to be returned to the [Facility] on 1/14/24 to resume her rehab. On the morning of 1/15/24 patient apparently transferred herself from the bed and possibly was attempting to walk toward the bathroom when she lost her balance and experienced another fall. There was ensuing pain in the left hip and along the full length of the lateral (outside) left femur prompting the order for a X-ray of the LLE (left lower extremity). The results were NEG(-) for showing any acute fracture or dislocation. However, patient is experiencing significant pain in the left hip which radiates along the tensor fascia [NAME] (muscle located in the upper outer thigh and hip) in distally to the lateral (outside) left knee. The pain is intense and increases with any attempt to move the left LE actively or passively from the current angulation (angle) described as left hip flexion (pulling the knee close to the chest), excessive across-midline adduction (brining the hip towards the midline of the body), and internal rotation (happens when you twist your thigh inward from your hip joint). Pt's therapy will be addressing her declines in mobility and performance of ADLs due to her decreases in endurance, strength, and balance for upright positioning .History of Falls .The most recent fall on the morning of 01/15/24 resulting in strains/contusion to the lateral left hip/thigh/knee causing pain and challenges for movement (whether active or passive) for left hip. Attempts to passive move the left leg is met with protective guarding and resistance .Pain assessment .Pain at rest-4/10 (scale used where 0 is no pain 10 is most severe pain); frequency-constant, daily, location-left hip, Description-gnawing, heavy, throbbing, dull ache and burning .Pain with movement-9/10-Frequency- Daily, intermittent- location- Left hip/thigh/knee laterally. Pain description-Burning, aching, cramping and sharp, quick . Record review of Resident #1's OT evaluation and plan of treatment completed by the DOR, dated 01/15/24 reflected, .Once admitted , patient had a fall and was sent back out to hospital and was dx (diagnosed) with NSTEMI. She has returned to this facility with therapy eval orders in place. She has already had another fall at this facility, c/o L hip pain, and was ordered Xray, which was negative for fracture. Upon eval, pt was unable to straighten LE, and remained in severe IR (internal rotation) to L hip. Nursing notified, and patient was assisted for improved positioning of LLE. She still complains 9/10 pain to L hip .Pain Assessment-Patient verbalized pain level .Paint at rest-4/10 .Pain with movement .9/10 .What relieves pain .sitting down, remaining still .What exacerbates pain .sitting, standing, bending, prolonged activity . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's falls summary report from 01/14/24 through 04/15/24 did not indicate a fall for Resident #1 on 01/14/24 or 01/15/24. Record Review of Resident #1's physician's orders for January 2024 did not reflect an order for X-ray for 01/15/24 or 01/18/24. Resident #1 did have Tramadol 50 mg 1 tablet every 6 hours as needed for pain with a start date of 01/14/24. Record review of Resident #1's Narcotic disposition form dated 01/18/24 for Tramadol 50 mg 1 tab every 6 hours as needed for pain, reflected the resident was treated for pain on 01/18/24, 01/19/24, 01/20/24, 01/21/24, 01/22/24 (2x), 01/24/24, 01/25/24 (2x), 01/26/24, 01/27/24, 01/28/24 (2x), 01/29/24, 01/30/24(2x), 01/31/24, 02/01/24, 02/02/24, 02/03/24 (2x), and 02/04/24. Record review of Resident #1's TAR from 01/14/24 through 02/04/24 reflected, Every shift check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale mild, moderate, severe, very severe. Shift 1 from 01/14/24 through 02/04/24 indicated no pain. Shift 2 indicated- no pain from 01/14/24-01/17/24, 01/18/24-01/20/21- moderate pain, 01/21/24- no pain, 01/22/24-moderate, 01/23/24-no pain, 01/24/24- moderate pain, 01/25/24- no pain, 01/26/24-01/28/24-moderate pain, 01/29/24-no pain, 01/30/24-02/01/24 moderate pain, 02/02/24-02/04/24- no pain. Record review of the Radiology report dated 01/15/24 completed at 11:25 a.m. reflected, Femur min 2 views, left- Results .Negative left hip. Atherosclerotic vascular disease (buildup of plaque in arteries). The report was signed by the MD and noted by Agency LVN P as reviewed on 01/15/24. Record review of Resident #1's Nurse Progress note completed by Agency LVN P on 01/15/2024 at 02:01 p. m. reflected, residents femur x-ray report: conclusion: negative left hip, atherosclerotic vascular disease. There were no indications the responsible party were notified. Record review of the Radiology report dated 01/18/24 completed at 02:41 p.m. reflected, Conclusion: Interval increase in angulation (alteration of aliment) of the intertrochanteric left femoral (type of thigh bone fracture) fracture as noted. Compare with 01/15/24. Record review of the e-mail provided to the facility from the contracted radiology company on 04/17/24 reflected the following timeline: X-ray Ordered: 01/18/24 at 01:04 p.m.- completed on 01/18/24 at 02:20 p.m. Resulted on 01/18/24 at 02:41 p.m. Faxed to the facility on [DATE] at 02:45 p.m. Unsuccessful attempts called to facility at 01/18/24 at 04:59 p.m. and 05:47 p.m. Record review of Resident #1's NP's note dated 01/18/24 at 01:01 p.m. reflected, .Seen today without issues or concerns .Status post fall. No reports of syncope (dizziness). CT of the brain was negative. Fall precautions .plan of care reviewed and discussed with [MD] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital record dated 02/13/24 reflected, admitted to [Facility X] on 02/05/24 from [Facility Y] with left hip pain. Patient requested repeat X-ray today due to pain not getting any better. X-Ray showing left femoral neck fracture. Alert and oriented x 4, incontinent due to pain. Surgical repair of her left hip fracture was completed on 02/14/24. In an interview with LVN F on 04/16/24 at 10:15 p.m. she stated she worked the 06:00 a.m. to 06:00 p.m. shift. She stated she worked on 01/14/24 when Resident #1 was readmitted to the facility. She stated she did not recall her having any additional falls on her return to the facility. She stated she was off from 01/15/24 through 01/27/28. She stated the process when they received an order for an x-ray was to place the order in the resident's electronic record, place the order in the radiology request portal, place it on the 24-hour report and make a note in the progress note of the pending request and any assessment needed that resulted in the request. She stated once the results were received, they were to notify the family and MD and document in the progress note the notification was completed and sign off on the X-ray result and place it in the MD's box for their review. LVN F searched Resident #1's electronic record and stated there were no X-Ray results uploaded into the record. She stated the progress note dated 01/15/24 reflected an X-ray had been completed and was negative. LVN F searched the radiology portal and stated there were copies of the X-ray results for 01/15/24 and stated there was another report for 01/18/24. She stated the X-ray request for 01/18/24 was put into the system by ADON A. She stated the X-ray for 01/18/24 showed a fracture. She stated she was unaware the resident had a fracture. She stated that surprised her since the resident had not complained of pain to her. She stated the X-ray company would fax the results but would also call if the X-ray was positive for a fracture. In an interview with PTA S on 04/16/24 at 10:30 a.m. he stated Resident #1 had expressed to PT R during his assessment she had fallen again, but stated there was some confusion if she had fallen on the re-admission or if it was the fall, she had on her first admission on 01/09/24. He stated she was expressing pain the first day of therapy on 01/15/24, but after that she did not complain and was progressing slowly with therapy. He stated he knew the X-ray on 01/15/24 was negative for a fracture, so they proceeded forward with therapy. He stated he was unaware of the X-Ray completed on 01/18/24 and was shocked she had a fracture. In an interview with the NP on 04/16/24 at 10:40 p.m. she stated she vaguely remembered Resident #1. She stated she saw the resident 3 x week during her stay at the facility and she did not recall her ever complaining to her about pain in her hip. She stated she did not recall ordering an X-ray for the resident on 01/15/24 or 01/18/24. She stated she would usually place anything like that in her notes to ensure she followed up. She stated the nurse's may have mentioned it to her in passing and she gave a verbal OK for the X-Ray. She stated the facility would call her or the MD with the results of the X-ray and they placed a copy of the report in the MD's communication box for her and the MD to review. She stated she did not ever see an X-ray that showed a fracture to the resident's femur. She stated if she had she seen it they would have sent her out to the hospital for further evaluation and treatment immediately. In an interview with COTA Q on 04/16/24 at 11:00 a.m. she stated the DOR was off until 04/18/24. She stated the DOR had assessed Resident #1 on 01/15/24 and the resident had expressed severe pain in her left hip. She stated it was reported to nursing and an X-ray was obtained, which showed to be negative. She stated they continued to provide OT services to the resident for the remainder of her stay at the facility. She stated the resident did not complain of pain after 01/16/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with ADON A on 04/16/24 at 11:30 a.m. she stated she was covering for the DON on the week of 01/15/24. She stated it was a crazy week, stating she had family who were also in the hospital during that time. She stated in addition they were using a lot of agency nurses. She stated she did not recall what prompted her to request the X-ray on 01/18/24 for Resident #1. She stated she did not recall being notified from PT or OT that Resident #1 had reported another fall on 01/15/24. She stated she should have placed an order in the resident's chart for the X-ray on 01/18/24 and should have placed it on the 24-hour report for follow up. She stated the nursing staff should have documented in the progress notes any complaints of pain the resident had and if PT had indicated a fall, and an incident report should have been completed. She stated she was unsure how the X-ray report was never reviewed by nursing or the physician. In an interview with CNA L on 04/16/24 at 11:45 a.m. she stated she worked with Resident #1 when she returned to the facility on [DATE]. She stated she was not aware of any additional falls for Resident #1 and did not recall her complaining of pain. Attempted to reach Agency LVN O on 04/16/24 at 12:14 p.m. by phone. No answer. Agency LVN O worked at the facility on 01/18/24 and was assigned to Resident #1's hall. In an interview with Facility X's DON on 04/16/24 at 12:20 p.m. she stated Resident #1 transferred to their facility on 02/05/24. She stated the resident had received therapy since her admission to their facility. She stated on 02/13/24 the resident requested a repeat X-ray of her left hip because she did not think Facility Y's X-rays were done correctly, since her left hip had continued to hurt. She stated they ordered an X-ray, which showed a left femur fracture. She stated the resident was sent to the hospital 02/13/24 and underwent surgical repair to her left hip. She stated the resident had since returned to the facility and was doing well. In an interview with PT R on 04/16/24 at 12:20 p.m. he stated he had reported to nursing on 01/15/24 about the resident's complaints of pain to her left hip, which was why an X-ray was ordered. He stated he did not recall if he reported to them about the resident's comments about falling that morning. He stated the X-Ray on 01/15/24 was negative, so they proceeded with therapy, but stated if a resident presented with symptoms or discomfort, they would back off therapy. He stated the resident did not present as someone with a hip fracture and was able to stand and ambulate for short distances. He stated it was not uncommon for a new admission to have more pain at first because they were sometimes waiting for the resident's pain medication to arrive. He stated the resident did not complain of pain after the first initial day and was making some progress in her therapy. He stated they will frequently ask nursing to request an X-ray if they have concerns about a possible fracture, but stated he did not request a second X-ray on 01/18/24. In an interview with the MD on 01/18/24 at 12:40 p.m. he stated he did not recall any calls from the facility regarding the results of an X-ray which showed a femur fracture for Resident #1. He stated had he been notified he would have sent her to the hospital immediately for treatment. He stated they would repeat an X-Ray if a resident continued to complain of pain and the initial X-ray was negative to make sure there was not a fracture. He stated the NP was in the facility three times a week and would update him of any changes in his patients. He stated he did not know why the radiology company did not contact him directly when they were unable to reach the facility. He stated an untreated fracture could result in death, increased pain, bleeding, and blood clots. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on 04/16/24 at 1:10 p.m. she stated she was on family medical leave during the week of 01/15/24 and ADON A was covering for her. She stated she had not been able to locate any incident report of a fall for Resident #1 since her readmission on 01/14/24. She stated agency staff do not have access to the radiology portal so a facility staff member would had to have put in the request for any X-ray. She stated the facility staff should ensure the X-ray order was placed in the electronic record and placed on the 24-hour report for follow up. She stated the agency staff were oriented to the electronic record and were provided access. She stated they should document any assessment of pain or notification to the family and physician. She stated she suspected when the fax copy of the X-ray report came in it was placed in the box to be scanned instead of the MD's box for review and when the Medical Records clerk picked up the reports, she did not notice it had not been reviewed by the physician or nursing. She stated she would be doing education with the Medical Records clerk to ensure those reports were placed back into the MD's box to ensure proper review. She stated the failure started with ADON A when she did not ensure an order was placed in the electronic record, a progress note notifying the family of the requested X-Ray and failing to place it on the 24-hour report. She stated had the ADON followed up even with the misplacement of the report, they would have been aware of the results of the X-Ray. In a telephone interview with Resident #1 on 04/16/24 at 1:50 p.m. she stated she was finally on the road to recovery. She stated she remembered very little about her stay at Facility Y. She stated she did not recall falling and was not sure if she fell more than once. She stated she did not know if she was having a lot of pain. She stated she remembered in February 2024 having pain in her left hip when she moved a certain way. She stated she just remembered her stay at Facility Y was not pleasant. She stated since she had her hip repaired, she was walking with a walker and getting much stronger. In an interview with Agency LVN P on 04/16/24 at 3:10 p.m. she stated she worked at the facility on 01/15/24, 01/16/24 and 01/17/24. She stated she did recall Resident #1 and remembered the physician had requested an X-ray on 01/15/24 due to hip pain. She stated she did not recall being told she had fallen. She stated she remembered Resident #1's family was with her most of the time, and would ask for pain medication for her, but stated when she assessed her for pain the resident would deny being in pain. She stated if she got an order for an X-ray, she would have to get one of the facility staff to place the request in the portal since she did not have access. She stated she would place the information about the X-ray on the 24-hour report and any notifications she made in the progress notes. Attempted to contact Agency LVN M on 04/16/24 at 4:22 p.m. who worked on 01/18/24. Unable to leave a message-voice mail was full. Record review of the facility policy titled Laboratory Testing, revised May 2023 reflected . Requests for diagnostic services must be ordered by the patient/resident's attending physician or physician extender . Orders for diagnostic services must be entered into the resident's medical record and signed by the attending physician or physician extender .Results of laboratory, radiological, and diagnostic tests shell be reported in writing to the resident's attending physician or physician extender or to the facility via fax or electronic reporting .The attending physician or physician extender shall be promptly notified of abnormal, critical, or stat test results. The charge nurse receiving the test results shall be responsible for notify the physician or physician extender of such test results in a timely manner . (continued on next page)

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	676394	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Place Rehabilitation Suites	5600 Woodlands Trail Denison, TX 75020

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the facility's policy, Physician and other communication/change in condition revised May 2023, revealed To improve communication between physician and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decision regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/resident's and their responsible party regarding change in condition .Complete assessment of the patient/resident which may include but is not limited to .Patient's/resident's previous condition .Recent labs, x-ray results .Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's/resident's condition in the medical record .The patient/resident and patient's /resident's family member/legal representative will be notified of any changes in medical condition or treatment plan . Review of facility's policy Abuse, neglect, exploitation, or mistreatment last revised October 2019 reflected The facility's Leadership prohibits neglect, mental, physical and/or verbal abuse, use of a physical and/or chemical restraint not required to treat a medical condition .and ensures that alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and are reported immediately Neglect is the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .In the event an employee is accused of abuse/neglect, that employee will be suspended during the investigation process . The Administrator was notified on 04/16/24 at 05:02 p.m. that an Immediate Jeopardy situation had been identified due to the above failures. The IJ template was provided at this time and plan of removal was requested. The facility's plan of removal was accepted on 04/17/24 at 05:22 p.m. The accepted plan of removal for the Immediate Jeopardy included the following: [Resident #1] is not currently in the facility. The allegation of neglect was reported to the state agency on 4/16/24 and is being thoroughly investigated. Appropriate actions will be taken as the investigation is conducted. The results of the investigation will be submitted to the state agency in 5 days. The responsible party of Resident #1 will be notified of the allegation 4/17/24 and subsequent investigation once completed. A house wide audit will be completed of x-rays completed since 1/1/24 to validate that any abnormal results have been reported to the physician for further direction, responsible parties have been notified and that physician orders for the x-ray are in the medical record. This will be completed by the Director of Nursing/Designee by 4/16/24. The facility activity report and the 24-hour report for the past 14 days will be audited by the Director of Nursing/ designee to identify any documentation that indicates a change of condition and validate that the physician has been contacted for further direction and the responsible party has been notified. This will be completed by 4/16/24. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility activity report and the 24hour report for the past 14 days will be audited by the Director of Nursing/Designee to identify any x-ray ordered and validate that the physician has been contacted with results for further direction and the responsible party notified. This will be completed by 4/16/24. The Administrator and Director of Nursing were reeducated by the Clinical Consultant on 4/16/24 on Abuse, Neglect & Misappropriation Policy, fall management and assessment of resident post fall that included: If a fall occurs, licensed nurse will evaluate the resident for injury and determine what may have caused or contributed to the fall and determines appropriate interventions to prevent future falls and completed a fall investigation worksheet. Licensed Nurses will continue to evaluate the resident 72hours post fall to identify any possible delayed injuries. Physician and responsible party will be promptly notified of a change of condition, including falls. Physician will be notified for additional injury, including pain for further orders. Responsible party will be notified for additional injuries. Residents showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition, notify the physician for further direction, and notify the responsible party. Requests for diagnostic services must be ordered by the resident's physician. Orders for diagnostic services will be promptly carried out as directed in the physician's order. Shift to shift report will be given to oncoming nurse for effective communication regarding resident care and treatment, including changes of condition, new orders, incidents/accidents and follow up for diagnostic services. The Administrator and Director of Nursing were reeducated by the Clinical Consultant on 4/17/24 on change of condition including. Residents showing signs of a change of condition will be assessed to appropriately identify and document the acute change in condition and notify the physician for further direction. Assessment may include but not limited to a. Residents physical condition b. Residents previous condition c. Vital signs, including pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. Recent labs, x-rays e. Previous and current mental status f. Medications g. Resident wishes h. Any interventions provided to the resident. Licensed Nurse will notify responsible party of residents change in condition. Identified Assistant Director of Nursing was reeducated by the Director of Nursing on 4/16/24 on Abuse, Neglect & Misappropriation Policy, fall management and assessment of resident post fall that included: If a fall occurs, licensed nurse will evaluate the resident for injury and determine what may have caused or contributed to the fall and determines appropriate interventions to prevent future falls and completed a fall investigation worksheet. Licensed Nurses will continue to evaluate the resident 72hours post fall to identify any possible delayed injuries. Physician and responsible party will be promptly notified of a change of condition, including falls. Physician will be notified for additional injury, including pain for further orders. Residents showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition and notify the physician for further direction. Requests for diagnostic services must be ordered by the resident's physician. Orders for diagnostic services will be promptly carried out as directed in the physician's order. Shift to shift report will be given to oncoming nurse for effective communication regarding resident care and treatment, including changes of condition, new orders, incidents/accidents and follow up for diagnostic services. Identified Assistant Director of Nursing was suspended on 4/16/24 pending investigation. Identified therapist was reeducated by the Director of Nursing on 4/17/24 regarding change in conditions that require notifications to the charge nurse including: Resident complaining of new or increased pain. Resident has a change in condition including the ability to bear weight. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Nurses and Therapy Staff will be reeducated on 4/17/24 by the Director of Nursing/Designee on the fall management policy including reporting of falls, this includes self-reported falls which must include evaluation of the resident for injury and investigation using a fall investigation worksheet to determine what may have caused or contributed to the fall or self-reported fall, notification to physician for further orders and notification to the responsible party. Any member of the target audience not receiving this education by 4/17/24 will receive prior to their next scheduled shift. Licensed nurses will be reeducated by the Director of Nursing/Designee on Abuse, Neglect & Misappropriation of Property Policy, fall management and assessment of resident post fall that includes: If a fall occurs, licensed nurse will evaluate the resident for injury and determine what may have caused or contributed to the fall and determines appropriate interventions to prevent future falls and completed a fall investigation worksheet. Licensed Nurses will continue to evaluate the resident 72hours post fall to identify any possible delayed injuries. Physician and responsible party will be promptly notified of a change of condition, including falls. Physician will be notified for additional injury, including pain for further orders. Responsible party will be notified for additional injuries. Residents showing signs of a change of condition should be assessed to appropriately identify and document the acute change in condition, notify the physician for further direction, and notify the responsible party. Requests for diagnostic services must be ordered by the resident's physician. Orders for diagnostic services will be promptly carried out as directed in the physician's order. Shift to shift report will be given to oncoming nurse for effective communication regarding resident care and treatment, including changes of condition, new orders, incidents/accidents and follow up for diagnostic services. Licensed Nurses will be reeducated on 4/17/24 by the Director of Nursing/Designee on change of condition including: Residents showing signs of a change of condition will be assessed to appropriately identify and document the acute change in condition and notify the physician for further direction. Assessment may include but not limited to i. Residents physical condition (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	j. Residents previous condition k. Vital signs, including pain. l. Recent labs, x-rays m. Previous and current mental status n. Medications o. Resident wishes p. Any interventions provided to the resident. Licensed Nurse w [TRUNCATED]

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on interview and record review the facility failed to promptly notify the ordering physician, results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner for one of six residents (Resident #1) reviewed for diagnostic services in that. 1.ADON A failed to read Resident #1's x-ray results received at the facility on 01/18/24 and failed to notify/consult the Physician about the resident's femur (thigh bone) fracture and change of condition using the facility's approved notification methods leaving Resident #1 with an undiagnosed /untreated fracture for 29 days (01/18/24 to 02/13/24). 2. The facility failed to have a system in place to ensure verbal notification was promptly received from the contracted Radiology company. Resident #1 fell on [DATE] at 03:15 a.m. with no apparent injury, but when attempting to get up, the resident's legs kept giving way. Resident #1 transported to the hospital and returned to the facility on [DATE] with no known fractures. On 01/15/24 Resident #1 complained of excruciating pain to her left leg and reported having an additional fall to PT R and the DOR/OT during their assessments. An X-ray was completed on 01/15/24 which was negative. On 01/18/24 another X-ray was obtained which showed a left intertrochanteric femoral fracture (type of hip fracture). The physician or family were never notified. Resident #1 was transferred to Facility X on 02/05/24 due to needing a Medicaid pending bed. Resident #1 continued to receive physical therapy at Facility X. On 02/13/24 Resident #1 was sent to the hospital due to continued hip pain and an X-ray confirmed a left hip fracture. Resident #1 received surgery to repair the hip fracture on 02/15/24, 29 days after the initial X-ray which showed the fracture. An Immediate Jeopardy (IJ) was identified on 04/16/24 at 04:45 p.m. The IJ template was provided to the facility on [DATE] at 05:02 p.m. and signed by the Administrator. While the IJ was removed on 04/18/24 at 01:15 p.m. the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm and a scope of isolated due to the facility still monitoring the effectiveness of their Plan of Removal. These failures resulted in delayed medical treatment, ongoing pain, delay in rehabilitation, hospitalization and placed the resident at risk of death, bleeding, and increased severity of the initial fracture. Findings include: Record review of Resident #1's 5-day MDS assessment, dated 01/20/24, reflected a [AGE] year-old female admitted to the facility on [DATE] and a re-admission on 01/14/24. Resident #1 had a BIMS of 12 which indicated her cognition was moderately impaired. Resident #1 required partial to substantial assistance with ADLs. Her diagnoses included coronary artery disease, myocardial infarction (heart attack), COVID-19, and unspecified fall. The assessment indicated the resident had zero fall since re-admission and had no pain. She had received PT and OT services with a start date of 01/15/24. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's base line care plan dated 01/09/24, reflected, Resident is a new admission . post cardiac stents and COVID positive .Goals .Resident's immediate health and safety needs will be identified .Approach .Fall Risk .Minimize falls .Encourage use of call eight .Pain Management .Monitor Pain . Verbal/descriptor .Location .General Treatment-see Physician orders . Record review of Resident #1's PT evaluation and Plan of treatment completed by PT R, dated 01/15/24 reflected, .Patient subsequently was originally admitted to the [facility] on 1/09/24 in order to participate with rehab. However, she had experienced a backward fall after her admittance hitting her posterior (back) aspect of the head on the floor. She was returned to [Hospital name] for evaluation on 1/10/24. Following all of the routine tests at the hospital patient was diagnosed with NSTEMI (type of partial blockage of one of the coronary arteries, causing reduced flow of oxygen-rich blood to the heart). She was treated and eventually deemed clinically stabilized sufficiently to be returned to the [Facility] on 1/14/24 to resume her rehab. On the morning of 1/15/24 patient apparently transferred herself from the bed and possibly was attempting to walk toward the bathroom when she lost her balance and experienced another fall. There was ensuing pain in the left hip and along the full length of the lateral (outside) left femur prompting the order for a X-ray of the LLE (left lower extremity). The results were NEG(-) for showing any acute fracture or dislocation. However, patient is experiencing significant pain in the left hip which radiates along the tensor fascia [NAME] (muscle located in the upper outer thigh and hip) in distally to the lateral (outside) left knee. The pain is intense and increases with any attempt to move the left LE actively or passively from the current angulation (angle) described as left hip flexion (pulling the knee close to the chest), excessive across-midline adduction (brining the hip towards the midline of the body), and internal rotation (happens when you twist your thigh inward from your hip joint). Pt's therapy will be addressing her declines in mobility and performance of ADLs due to her decreases in endurance, strength, and balance for upright positioning .History of Falls .The most recent fall on the morning of 01/15/24 resulting in strains/contusion to the lateral left hip/thigh/knee causing pain and challenges for movement (whether active or passive) for left hip. Attempts to passive move the left leg is met with protective guarding and resistance .Pain assessment .Pain at rest-4/10 (scale used where 0 is no pain 10 is most severe pain); frequency-constant, daily, location-left hip, Description-gnawing, heavy, throbbing, dull ache and burning .Pain with movement-9/10-Frequency- Daily, intermittent- location- Left hip/thigh/knee laterally. Pain description-Burning, aching, cramping and sharp, quick . Record review of Resident #1's OT evaluation and plan of treatment completed by the DOR, dated 01/15/24 reflected, .Once admitted , patient had a fall and was sent back out to hospital and was dx (diagnosed) with NSTEMI. She has returned to this facility with therapy eval orders in place. She has already had another fall at this facility, c/o L hip pain, and was ordered Xray, which was negative for fracture. Upon eval, pt was unable to straighten LE, and remained in severe IR (internal rotation) to L hip. Nursing notified, and patient was assisted for improved positioning of LLE. She still complains 9/10 pain to L hip .Pain Assessment-Patient verbalized pain level .Paint at rest-4/10 .Pain with movement .9/10 .What relieves pain .sitting down, remaining still .What exacerbates pain .sitting, standing, bending, prolonged activity . Record review of the facility's falls summary report from 01/14/24 through 04/15/24 did not indicate a fall for Resident #1 on 01/14/24 or 01/15/24. Record Review of Resident #1's physician's orders for January 2024 did not reflect an order for X-ray for 01/15/24 or 01/18/24. Resident #1 did have Tramadol 50 mg 1 tablet every 6 hours as needed for pain with a start date of 01/14/24. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Narcotic disposition form dated 01/18/24 for Tramadol 50 mg 1 tab every 6 hours as needed for pain, reflected the resident was treated for pain on 01/18/24, 01/19/24, 01/20/24, 01/21/24, 01/22/24 (2x), 01/24/24, 01/25/24 (2x), 01/26/24, 01/27/24, 01/28/24 (2x), 01/29/24, 01/30/24(2x), 01/31/24, 02/01/24, 02/02/24, 02/03/24 (2x), and 02/04/24. Record review of Resident #1's TAR from 01/14/24 through 02/04/24 reflected, Every shift check resident for level of pain utilizing numeric rating scale 0-10 or verbal descriptor scale mild, moderate, severe, very severe. Shift 1 from 01/14/24 through 02/04/24 indicated no pain. Shift 2 indicated- no pain from 01/14/24-01/17/24, 01/18/24-01/20/21- moderate pain, 01/21/24- no pain, 01/22/24-moderate, 01/23/24-no pain, 01/24/24- moderate pain, 01/25/24- no pain, 01/26/24-01/28/24-moderate pain, 01/29/24-no pain, 01/30/24-02/01/24 moderate pain, 02/02/24-02/04/24- no pain. Record review of the Radiology report dated 01/15/24 completed at 11:25 a.m. reflected, Femur min 2 views, left- Results .Negative left hip. Atherosclerotic vascular disease (buildup of plaque in arteries). The report was signed by the MD and noted by Agency LVN P as reviewed on 01/15/24. Record review of Resident #1's Nurse Progress note completed by Agency LVN P on 01/15/2024 at 02:01 p. m. reflected, residents femur x-ray report: conclusion: negative left hip, atherosclerotic vascular disease. There were no indications the responsible party were notified. Record review of the Radiology report dated 01/18/24 completed at 02:41 p.m. reflected, Conclusion: Interval increase in angulation (alteration of aliment) of the intertrochanteric left femoral (type of thigh bone fracture) fracture as noted. Compare with 01/15/24. Record review of the e-mail provided to the facility from the contracted radiology company on 04/17/24 reflected the following timeline: X-ray Ordered: 01/18/24 at 01:04 p.m.- completed on 01/18/24 at 02:20 p.m. Resulted on 01/18/24 at 02:41 p.m. Faxed to the facility on [DATE] at 02:45 p.m. Unsuccessful attempts called to facility at 01/18/24 at 04:59 p.m. and 05:47 p.m. Record review of Resident #1's NP's note dated 01/18/24 at 01:01 p.m. reflected, .Seen today without issues or concerns .Status post fall. No reports of syncope (dizziness). CT of the brain was negative. Fall precautions .plan of care reviewed and discussed with [MD] . Record review of the Facility's 24-hour report for 01/18/24 and 01/19/24 did not reflect any follow up for X-Ray and indicated no change in Resident #1. Record review of Resident #1's Nurse Progress notes and daily observation note for 01/18/24 did not indicate an order was received to repeat Resident #1's X-ray. No indication of pain or complaints. Record review of Resident #1's hospital record dated 02/13/24 reflected, admitted to Facility X on 02/05/24 from Facility Y with left hip pain. Patient requested repeat X-ray today due to pain not getting any better. X-Ray showing left femoral neck fracture. Alert and oriented x 4, incontinent due to pain. Surgical repair of her left hip fracture was completed on 02/14/24. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN F on 04/16/24 at 10:15 p.m. she stated she worked the 06:00 a.m. to 06:00 p.m. shift. She stated she worked on 01/14/24 when Resident #1 was readmitted to the facility. She stated she did not recall her having any additional falls on her return to the facility. She stated she was off from 01/15/24 through 01/27/28. She stated the process when they received an order for an x-ray was to place the order in the resident's electronic record, place the order in the radiology request portal, place it on the 24-hour report and make a note in the progress note of the pending request and any assessment needed that resulted in the request. She stated once the results were received, they were to notify the family and MD and document in the progress note the notification was completed and sign off on the X-ray result and place it in the MD's box for their review. LVN F searched Resident #1's electronic record and stated there were no X-Ray results uploaded into the record. She stated the progress note dated 01/15/24 reflected an X-ray had been completed and was negative. LVN F searched the radiology portal and stated there were copies of the X-ray results for 01/15/24 and stated there was another report for 01/18/24. She stated the X-ray request for 01/18/24 was put into the system by ADON A. She stated the X-ray for 01/18/24 showed a fracture. She stated she was unaware the resident had a fracture. She stated that surprised her since the resident had not complained of pain to her. She stated the X-ray company would fax the results but would also call if the X-ray was positive for a fracture. In an interview with PTA S on 04/16/24 at 10:30 a.m. he stated Resident #1 had expressed to PT R during his assessment she had fallen again, but stated there was some confusion if she had fallen on the re-admission or if it was the fall, she had on her first admission on 01/09/24. He stated she was expressing pain the first day of therapy on 01/15/24, but after that she did not complain and was progressing slowly with therapy. He stated he knew the X-ray on 01/15/24 was negative for a fracture, so they proceeded forward with therapy. He stated he was unaware of the X-Ray completed on 01/18/24 and was shocked she had a fracture. In an interview with the NP on 04/16/24 at 10:40 p.m. she stated she vaguely remembered Resident #1. She stated she saw the resident 3 x week during her stay at the facility and she did not recall her ever complaining to her about pain in her hip. She stated she did not recall ordering an X-ray for the resident on 01/15/24 or 01/18/24. She stated she would usually place anything like that in her notes to ensure she followed up. She stated the nurse's may have mentioned it to her in passing and she gave a verbal OK for the X-Ray. She stated the facility would call her or the MD with the results of the X-ray and they placed a copy of the report in the MD's communication box for her and the MD to review. She stated she did not ever see an X-ray that showed a fracture to the resident's femur. She stated if she had she seen it they would have sent her out to the hospital for further evaluation and treatment immediately. In an interview with ADON A on 04/16/24 at 11:30 a.m. she stated she was covering for the DON on the week of 01/15/24. She stated it was a crazy week, stating she had family who were also in the hospital during that time. She stated in addition they were using a lot of agency nurses. She stated she did not recall what prompted her to request the X-ray on 01/18/24 for Resident #1. She stated she did not recall being notified from PT or OT that Resident #1 had reported another fall on 01/15/24. She stated she should have placed an order in the resident's chart for the X-ray on 01/18/24 and should have placed it on the 24-hour report for follow up. She stated the nursing staff should have documented in the progress notes any complaints of pain the resident had and if PT had indicated a fall, and an incident report should have been completed. She stated she was unsure how the X-ray report was never reviewed by nursing or the physician. (continued on next page)

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	676394	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlands Place Rehabilitation Suites	5600 Woodlands Trail Denison, TX 75020

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempted to reach Agency LVN O on 04/16/24 at 12:14 p.m. by phone. No answer. Agency LVN O worked at the facility on 01/18/24 and was assigned to Resident #1's hall. In an interview with Facility X's DON on 04/16/24 at 12:20 p.m. she stated Resident #1 transferred to their facility on 02/05/24. She stated the resident had received therapy since her admission to their facility. She stated on 02/13/24 the resident requested a repeat X-ray of her left hip because she did not think Facility Y's X-rays were done correctly, since her left hip had continued to hurt. She stated they ordered an X-ray, which showed a left femur fracture. She stated the resident was sent to the hospital 02/13/24 and underwent surgical repair to her left hip. She stated the resident had since returned to the facility and was doing well. In an interview with PT R on 04/16/24 at 12:20 p.m. he stated he had reported to nursing on 01/15/24 about the resident's complaints of pain to her left hip, which was why an X-ray was ordered. He stated he did not recall if he reported to them about the resident's comments about falling that morning. He stated the X-Ray on 01/15/24 was negative, so they proceeded with therapy, but stated if a resident presented with symptoms or discomfort, they would back off therapy. He stated the resident did not present as someone with a hip fracture and was able to stand and ambulate for short distances. He stated it was not uncommon for a new admission to have more pain at first because they were sometimes waiting for the resident's pain medication to arrive. He stated the resident did not complain of pain after the first initial day and was making some progress in her therapy. He stated they will frequently ask nursing to request an X-ray if they have concerns about a possible fracture, but stated he did not request a second X-ray on 01/18/24. In an interview with the MD on 01/18/24 at 12:40 p.m. he stated he did not recall any calls from the facility regarding the results of an X-ray which showed a femur fracture for Resident #1. He stated had he been notified he would have sent her to the hospital immediately for treatment. He stated they would repeat an X-Ray if a resident continued to complain of pain and the initial X-ray was negative to make sure there was not a fracture. He stated the NP was in the facility three times a week and would update him of any changes in his patients. He stated he did not know why the radiology company did not contact him directly when they were unable to reach the facility. He stated an untreated fracture could result in death, increased pain, bleeding, and blood clots. In an interview with the DON on 04/16/24 at 1:10 p.m. she stated she was on family medical leave during the week of 01/15/24 and ADON A was covering for her. She stated she had not been able to locate any incident report of a fall for Resident #1 since her readmission on 01/14/24. She stated agency staff do not have access to the radiology portal so a facility staff member would had to have put in the request for any X-ray. She stated the facility staff should ensure the X-ray order was placed in the electronic record and placed on the 24-hour report for follow up. She stated the agency staff were oriented to the electronic record and were provided access. She stated they should document any assessment of pain or notification to the family and physician. She stated she suspected when the fax copy of the X-ray report came in it was placed in the box to be scanned instead of the MD's box for review and when the Medical Records clerk picked up the reports, she did not notice it had not been reviewed by the physician or nursing. She stated she would be doing education with the Medical Records clerk to ensure those reports were placed back into the MD's box to ensure proper review. She stated the failure started with ADON A when she did not ensure an order was placed in the electronic record, a progress note notifying the family of the requested X-Ray and failing to place it on the 24-hour report. She stated had the ADON followed up even with the misplacement of the report, they would have been aware of the results of the X-Ray. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with Resident #1 on 04/16/24 at 1:50 p.m. she stated she was finally on the road to recovery. She stated she remembered very little about her stay at Facility Y. She stated she did not recall falling and was not sure if she fell more than once. She stated she did not know if she was having a lot of pain. She stated she remembered in February 2024 having pain in her left hip when she moved a certain way. She stated she just remembered her stay at Facility Y was not pleasant. She stated since she had her hip repaired, she was walking with a walker and getting much stronger. In an interview with Agency LVN P on 04/16/24 at 3:10 p.m. she stated she worked at the facility on 01/15/24, 01/16/24 and 01/17/24. She stated she did recall Resident #1 and remembered the physician had requested an X-ray on 01/15/24 due to hip pain. She stated she did not recall being told she had fallen. She stated she remembered Resident #1's family was with her most of the time, and would ask for pain medication for her, but stated when she assessed her for pain the resident would deny being in pain. She stated if she got an order for an X-ray, she would have to get one of the facility staff to place the request in the portal since she did not have access. She stated she would place the information about the X-ray on the 24-hour report and any notifications she made in the progress notes. Attempted to contact Agency LVN M on 04/16/24 at 4:22 p.m. who worked on 01/18/24. Unable to leave a message-voice mail was full. Record review of the facility policy titled Laboratory Testing, revised May 2023 reflected . Requests for diagnostic services must be ordered by the patient/resident's attending physician or physician extender . Orders for diagnostic services must be entered into the resident's medical record and signed by the attending physician or physician extender .Results of laboratory, radiological, and diagnostic tests shell be reported in writing to the resident's attending physician or physician extender or to the facility via fax or electronic reporting .The attending physician or physician extender shall be promptly notified of abnormal, critical, or stat test results. The charge nurse receiving the test results shall be responsible for notify the physician or physician extender of such test results in a timely manner . Record review of the facility's policy, Physician and other communication/change in condition revised May 2023, revealed To improve communication between physician and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decision regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/resident's and their responsible party regarding change in condition .Complete assessment of the patient/resident which may include but is not limited to .Patient's/resident's previous condition .Recent labs, x-ray results .Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's/resident's condition in the medical record .The patient/resident and patient's /resident's family member/legal representative will be notified of any changes in medical condition or treatment plan . The Administrator was notified on 04/16/24 at 05:02 p.m. that an Immediate Jeopardy situation had been identified due to the above failures. The IJ template was provided at this time and plan of removal was requested. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/Designee and/or Manager on Duty will review the 24-hour report and the facility activity report to identify any documentation regarding a change of condition, including falls, and validate that the resident has been assessed appropriately, physician notified, RP/Family notified, and orders implemented promptly. This includes diagnostic testing and results. This will be completed Monday -Friday in the Clinical Meeting and Charge Nurse on weekends. Facility Medical Director will be notified of the Immediate Jeopardy and the contents of this plan on 4/16/24 and will be given progress updates. Monitoring The facility's implementation of the IJ Plan of Removal was verified through the following: Record Review of an e-mail dated 04/17/24 sent to the radiology company indicated the facility's request for any X-ray outside of the normal parameters were to the Administrator, DON, the Medical Director, or The Attending physician. Cell phone numbers were provided to the company. Record review of the facility's Summary Utilization Report dated 01/01/24 through 04/16/24 reflected a 100% audit of all radiology requests made had been reviewed and verified physician notification was made on all request except for Resident #1 on 01/18/24. Record review of facility's in-service initiated on 04/16/24 by the Clinical Service Director reflected the DON was in-serviced on the facility's policy on Abuse and Neglect, fall management and assessment of the resident post fall, significant changes of condition and the facility's lab and radiology procedure for notification to physician. In an interview with the DON on 04/18/24 at 9:30 a.m. she stated the root cause of this failure was the ADON's failure to follow procedure and failure to follow up. She stated it was her expectation for any nurse who received an order due to a change of condition to follow up on the resident, notify the physician and family. She stated staff must report from shift to shift when there had been a change so ongoing follow up could continue. She stated she monitored for this by making daily rounds, following up after daily stand-up meetings and review of the 24-hour report. She stated going forward therapy had been instructed to notify her as well as the nursing staff on any changes in a resident's condition so she will be assured required follow up is completed. Record review of the Shift-to-Shift verification report reflected on 04/16/24 the DON participated in the 6 p.m. to 6 a.m. shift report and ADON B participated in the shift-to-shift report for the 6 a.m. to 6 p.m. shift changes. Record review of the facility's inservice initiated on 04/16/24 by the Clinical Service Director reflected the Administrator was in serviced on the facility policy for abuse and neglect. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the MD on 04/18/24 at 10:54 a.m. he stated the facility had provided his contact information to the radiology company so he could be contacted directly if an X-ray was outside the normal parameters. He stated it was the expectation if the radiology company had not been able to reach anyone at the facility, they should had contacted him directly since he was the ordering physician of the X-ray request. He stated had they done that, the resident would have received timely care. He verified he had reviewed the facilities Plan of removal and stated he had reviewed with his NP his expectation for follow up on any of their residents for X-ray results. In an interview with the Administrator on 04/18/24 at 11:14 a.m. he stated he had been re-educated on abuse and neglect on 04/16/24. He stated he had self-reported the allegation of neglect involving Resident #1 and they had suspended ADON A until the completed investigation. He stated he felt the failure of the ADON resulted in neglect related to the failure to follow up on the X-ray which resulted in the physician never becoming aware of the results and the resident not receiving necessary treatment. He stated it was an unfortunate time since he was also off during that time frame as well. He stated he made daily rounds especially on the rehab hall, so residents know who to report any concerns to. He stated he had reached out to Resident #1's responsible party on 04/17/24 to inform them of the X-ray results and to let them know they were taking this failure very seriously and doing everything possible to ensure this never occurred again. He stated they had a conversation with the Radiology company and contact numbers were provided to them. He stated that way, even if he or the DON were not at the facility, they would be notified of any X-ray outside of the normal parameters so they could ensure proper notifications and follow up were completed. Record Review of the facility's Inservice Records dated 04/17/24 reflected staff were educated on Fall management, Abuse and neglect, signification changes in condition, physician notification and verification of Radiology request. Interviews conducted on 04/17/27 from 3:30 p.m. to 4:00 p.m. with 2nd shift charge nurses RN E and RN C revealed they had received in-service training and were able to verbalize understanding of the in-service training regarding x-rays to be completed in timely manner and to follow up to physician and responsible party. They were knowledgeable of the documentation process for placing the orders in the electronic record, notation on the X-ray results of their review and notification to the physician. The were aware of the fall and incident reporting criteria and communication to oncoming shifts of any changes through the 24-hour report. They were all knowledgeable of abuse/neglect policy on reporting, neglect definition including a delay in treatment and to report any allegations immediately. Interviews conducted on 04/18/24 from 08:34 a.m. to 10:05 a.m. with 1st and 2 shift staff, LVN H, LVN I, LVN F, LVN J, LVN K, and LVN G revealed they had received in-service training and were able to verbalize understanding of the in-service training regarding x-rays to be completed in timely manner and to follow up to physician and responsible party. They were knowledgeable of the documentation process for placing the orders in the electronic record, notation on the X-ray results of their review and notification to the physician. They were aware of the fall and incident reporting criteria and communication to oncoming shifts of any changes through the 24-hour report. They were all knowledgeable of abuse/neglect policy on reporting, neglect definition including a delay in treatment and to report any allegations immediately. (continued on next page)

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