STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676437	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at College Station	1500 Medical Avenue College Station, TX 77845

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one (Resident #1) of ten residents reviewed for care plans. The facility failed to ensure staff followed Resident #1's care plan on 03/26/25 when CNA A was giving her a bed bath alone and she slid from the bed onto the floor sustaining a severe laceration to her right hip and fracture to her left hip. An IJ was identified on 04/09/25. The IJ template was provided to the facility on [DATE] at 5:36 pm. While the IJ was removed on 04/09/25, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for negligence, injury, and hospitalization . Findings included: Review of Resident #1's face sheet, dated 04/09/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE], readmitted on [DATE] and 07/07/23 with diagnoses including Congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs, leading to fluid buildup in the body, particularly in the lungs and extremities), varicose veins (swollen, twisted, and enlarged veins, usually seen on the legs), and body mass index BMI 45.0 - 49.9 (indicates Class III obesity, also known as morbid obesity). Review of Resident #1's quarterly MDS assessment, dated 01/27/25, reflected a BIMS of 15, indicating resident had intact cognition. Review of Resident #1's quarterly care plan, revised on 11/24/21, reflected ADL performance deficit related to immobility, pain, and poor vision with interventions of: Toilet use - Resident #1 required (X2) staff participation to use toilet revised on 11/24/21 (continued on next page)

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

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Transfer - Resident #1 required (X2) staff participation with transfers revised on 11/24/21 Bed Mobility - Resident #1 required (X2) staff participation to reposition and turn in bed revised on 11/24/21 Bathing - Resident #1 required (X2) participation with bathing revised on 11/24/21 Review of Resident #1's hospital HPI dated 03/26/25 reflected Resident #1 presented to the ER after a fall. Resident lived at a nursing home and reportedly when they were changing the sheets she fell out of bed. In the ER she was found to have a left comminuted intertrochanteric fracture (a break in the femur (thigh bone) that occurs in the intertrochanteric region, specifically between the greater and lesser trochanters. This fracture type is often seen in older adults and can result from a fall or impact. The comminuted aspect means the fracture has multiple bone fragments making it a more unstable fracture) and a large V-shaped skin tear that was stabled in the ER. A review of the Texas Unified Licensure Information Portal for the facility revealed that on 03/26/25 the facility reported that on 03/26/25 CNA A administered ADL care to Resident #1 and rolled her to her right side. Resident #1 slid out of bed onto the floor. Resident #1 received a laceration to her right lower extremity and was sent to the emergency room . The facility later received notification that Resident #1 had a left hip fracture. Review of unsigned facility statement from CNA A dated 03/26/25 reflected, I [CNA A] was giving [Resident #1] a bed bath, when I turned her over to clean the other side of her she slid out of her bed on to the Floor. I ran fast to tell nurse. we came back with help to get her off the floor. her legs were bleeding bad, so the nurse called 911, the nurses wrapped her legs to slow some of the bleeding. By then the paramedics/EMT Came and took her to the hospital. A review of Resident #1's Progress Note by LVN B reflected he was called to Resident #1's room by staff and found resident on floor at bedside closest to window. Resident #1 was nude from ADL care and her lower extremities lay across the legs of the bedside table, while her head was partially resting against wheels of bed. Resident #1 was alert and oriented and able to converse about her condition. After returning resident to bed with assistance of staff and mechanical devise it was determined that the laceration on the upper part of right thigh required a physician's intervention. While additional staff nurses remained with resident to help control bleeding RN B returned to desk and called EMS and reported to hospital ER of impending transfer. Resident was transferred to [hospital] by EMS, MD was made aware, and DON was informed. Resident #1 was her own responsible party and concurred with the treatment plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility statement by the Administrator dated 03/27/25 9:15 am revealed she spoke with CNA A regarding the incident with Resident #1 and asked if she know how to read the Kardex (a concise nursing documentation system that summarizes key patient information, including medications, treatments, and daily care plans) and CNA said she did. Administrator asked her if she read it the morning of the incident with Resident #1 and CNA A said she did not. The Administrator asked CNA A how many people it took to assist Resident #1 and with peri care (cleaning the genital and anal areas to maintain hygiene and prevent infections) as well as other ADL's and CNA A said 2 (two). The Administrator asked CNA A if she used another person to assist Resident #1 and CNA A replied no, that the other aides were assisting other residents. The Administrator revealed she educated CNA A on the importance of reading the Kardex as well as following the Kardex and that it was to prevent any injuries to the resident. Review of facility statement by the Administrator dated 03/27/25 9:15 am revealed she asked CNA A to go to Resident #1's room and show her how the incident occurred. The Administrator said CNA A raised the bed to the position it was at the time of the incident and CNA A stated that when she got ready to turn [Resident #1] she pulled the sheet up and turned [Resident #1] on her right side. This is when [Resident #1's] left leg swung over the side of the bed causing [Resident #1] to slide off the bed landing on her stomach. [Resident #1's] head was by the front wheels of the bed and her legs were by the back wheels of the bed. [CNA A] stated that [Resident #1's] lower right leg was laying on the top of the bottom of the over the bed table. This table has a metal frame that holds the table with the bottom of the bedside table where [Resident #1's] right lower extremity landed. CNA A told the Administrator that there was blood at the bottom of the bedside table where [Resident #1's] right lower extremity landed. The Administrator said she asked if Resident #1 complained of pain to either of her hips and CNA A stated that [Resident #1] did not. Review of signed statement dated 03/26/25 of CNA C who stated I was sitting at the nurse's station when we were approached by [RN B] to assist with [Resident #1] that fell out of bed. I went to assist with the fall of [Resident #1]. I came to help get [Resident #1] off the floor. Review of signed statement dated 03/26/25 of CNA D who stated, I was sitting at the nurse's station when we were approached by [RN B] to assist with [Resident #1] that fell out of bed. I went to assist with the fall of [Resident #1]. I came and grabbed the [assistive device] to help assist until no longer needed. Attempted interview on 04/09/25 with Resident #1 at 11:42 am, who discharged to another facility after she discharged from the hospital, reflected, when phoning Resident #1, received a voice mail that the number requested could not be dialed and unable to interview Resident #1. Interview on 04/09/25 with a Family Member of Resident #1 at 11:25 am revealed Resident #1 no longer had a telephone. Family Member reported the facility staff, rolled [Resident #1] right off the bed. The Family member said there was a policy in place for Resident #1 to have 2 (two) people always go in and assist Resident #1 when she needed to be changed. The Family member reported Resident #1 had, 30 staples and 7 stitches and a broken hip. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An interview on 04/09/25 with CNA A at 12:36 pm reflected she felt like the facility was short staffed and she did not want to bother the other staff and ask for help. She said she had helped Resident #1 alone previously and Resident #1 had been sitting in urine and needed to be changed. CNA A said she did not purposely hurt Resident #1, but she did not ask for help to assist Resident #1. She said she had not been asked to return to work at the facility. CNA A said when Resident #1 fell , she ran to get a nurse and he assessed with getting Resident #1, using an assistive devise, off the floor. CNA A she was not trained on how to use the Kardex but did know that Resident #1 was a 2 (two) person assist when changing or moving Resident #1. A phone call interview on 04/10/25 with LVN B at 02:12 pm revealed he was the nurse on shift at time of Resident #1's fall on 03/26/25 and, to his knowledge the resident was a 2 (two) person assist. He said the Kardex contained information about Resident #1's ADLs and transfer status. LVN B stated the CNAs referred to the Kardex to determine the care needs of a resident and the Kardex was available to all CNAs. LVN B stated, he was not aware, at the time of the incident, that CNA A was providing care alone. LVN B stated he was informed by staff (staff name unknown) that Resident #1 had a large bowl movement and CNA A wanted to bath her after but stated that CNA A should have gotten help and that there was plenty of staff that night to assist and no reason for her to not ask for help. CNA B revealed, Why she chose not to do that I don't know, I was at the nurses station charting when she came to get me for help after. He stated if CNA A had told him that she was going to bathe Resident #1 he would have gotten up to help CNA A, but she did not inform him that she needed a second staff member to help her with Resident #1. He stated he was the charge nurse that night. He stated the caregiver was ultimately responsible for asked for assistance with residents because they knew the rules when they were given their assignments. LVN B stated anyone would be crazy to take a resident her size on by themselves and he did not know why to this day CNA A did not ask for help. LVN B recalled the resident's weight to be in the area of 260 plus pounds. Resident #1 was in a bariatric bed, and it was hard for LVN B to imagine that someone would attempt changing and cleaning her alone. When LVN B walked into the room to help after CNA A called him, he said it looked like she [CNA A] was getting ready to change the oil on the bed- that was never safe at any time for any patient especially someone with Resident #1's weight to have a bed that high. The aide should have gotten help, the call light was available there was always a way to get help. An interview on 04/10/25 with CNA C at 2:33 pm revealed she was at the nurses' station on the rehabilitation side of the facility when LVN B came to get her stating they needed help getting a resident off the floor. CNA C stated she saw the resident on the floor in between the wall and the bed and Resident #1's bed was pretty high up. CNA C stated prior to this event, she never worked with Resident #1 but upon seeing Resident #1, because of Resident #1 was a big woman, she would have known that Resident #1 was a 2 (two) person assist. CNA C stated that the number of staff assistance a resident required for safe resident care was in the Kardex located in EMR. A CNA could click on the Kardex to see if the resident was a one or two person assist. The CNA C said if there was not another person to assist a resident who was a 2 (two) person assist, she would ask a nurse to help or wait for a coworker to get help before assisting the resident. She said she did not recall how many staff members were working that night but said there were plenty of people listing herself, two aides, a nurse, and a nurse trainee. CNA C stated that CNA A could have also asked the people in the rehabilitation side of the facility for help. CNA C stated it was never appropriate to proceed with just one person if the resident was listed in the Kardex as a 2 (two) person assist. If the Kardex says the Resident require a 2 (two) person assist, you wait until you have 2 (two) people to assist. CNA C stated, you never know the condition or if they just had hip surgery, you always wait to have the amount of people you need. CNA C stated she has no idea why the CNA A did not ask for help that night. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A phone interview on 04/10/25 with CNA D at 2:50 pm revealed LVN B asked for help with a resident. CNA D she walked into Resident #1's room and saw Resident #1 on the floor and she went to grab the mechanical devise to lift help get Resident #1 off the floor. CNA D stated they needed a mechanical device due to Resident#1's size and also because of Resident #1's ADL abilities. CNA D stated she had worked with Resident #1 in the past and stated it was very obvious for anyone, even working with Resident #1 for the first time, to see that Resident #1 was a 2 (two) person assist based on her size and appearance. CNA D stated she would look at the Kardex to determine the level of assistance needed for residents. CNA D stated if she did not have the 2nd person needed to assist a resident, she would go find help and stated, you just have to ask for help. CNA D Stated it was never appropriate to proceed to assist without the help of others if they require 2 (two) or more even assist if it appeared manageable. CNA D stated it was everyone's responsibility to ensure the residents received the level of care they need. She stated she referred to the Kardex daily because something could change. She stated she would report any Kardex issues to her nurse or the Administrator as needed. In an interview on 04/10/25 with ADON at 6:02 pm she stated CNAs were ultimately responsible for ensuring the correct level of care for residents because they were trained and knew the procedures. She stated that agency and PRN staff also have access to the Kardex. She stated she was responsible for the PRN and new hire staff be aware of where to locate the Kardex which displays the care needs of the residents. She stated it was her expectation that they provided the highest level of care, that all residents needs were met in a safe, respectful, and dignified manner. The ADON stated that level of resident care and resident transfer status understanding was the knowledge that kept patients safe. She said that if staff knew the level of resident care needs it helped to makes sure residents remained safe. She stated that if the person was aware of the transfer status of a resident and did not follow the resident transfer status when providing resident care she would consider it negligence because they did not provide the safest level of care. An interview on 04/10/25 with the DON at 6:20 pm revealed she had been the DON at the facility for a week and a half and it was her expectation that the CNAs follow the Kardex that they have been trained to follow. She stated she would consider it negligence if a CNA knew the transfer status of a resident and failed to follow it and stated that CNA would require retraining. She stated that training for Kardex occurred frequently. An interview on 04/10/25 with the Administrator at 2:33 pm revealed staff needed to ensure the physical abilities and the level of the ADL care needed for residents when providing assistance. The CNAs can find out if residents require a 1 (one) or 2 (two) person level of assistance by referring to the Kardex. If there is not a 2nd staff member available, they need to wait until a 2nd staff member is available to provide resident care. An interview on 04/10/25 with the Administrator at 6:45 pm revealed it was the CNAs responsibility to ensure they were providing the care the resident required. She stated all PRN staff had access to the Kardex and knew how to locate it. She stated it was important to follow the transfer status due to resident safety as well as staff safety. She stated that when she asked CNA A why she didn't ask for help CNA A said that other CNAs were busy, and Resident #1 was impatient. Review of facility Falls and Fall Risk, Managing Policy dated April 2007 reflected based on previous evaluations and current data, the staff will identify interventions related to the resident specific risks and causes to try to prevent resident from falling and try to minimize complications from falling. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility Falls - Clinical Protocol dated April 2007 based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Review of the facility Abuse and Neglect - Clinical Protocol Assessment and Recognition policy dated April 2007 reflected neglect means failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness. Treatment/Management -The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The ADM was notified on 04/09/25 at 5:36 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 04/10/25 at 2:27 pm: The POR included: PLAN OF REMOVAL Date: April 9, 2025 The Texas Department of Health and Human Services entered facility on April 9, 2025 for a Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited regarding F656 Develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. The facility failed to follow Resident # 1's care plan when care was provided by one staff member only. Immediate action: What corrective actions have been implemented for the identified residents? Resident #1 discharged from the facility on 3-26-25 to the hospital and did not return to the facility. On 4-9-25, the Clinical Service Director in-serviced the nurse managers to include the DON to refer to the Kardex for the level of assistance: including 2 person assistance required by residents with ADL care. On 4-9-25, DON/designees in-serviced all direct care (full-time, part-time, and PRN) nursing staff to utilize Kardex to determine the level of assistance required to provide care. On 3-27-25, the Administrator educated CNA A to refer to the Kardex for the level of assistance: including 2 person assistance required by residents with ADL care. CNA A last day worked was 3-31-25. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	All direct care nursing staff (full-time, part-time, and PRN) will demonstrate and acknowledge that they are aware of how to identify and utilize the Kardex to review resident's care plan to identify the level of assistance: including 2 person assistance) required to provide ADL care. The Kardex was in the POC dashboard which is accessible by all direct care nursing staff in the facility. To access the employee will log into their POC, select the resident and then select the Kardex button located on the right-hand side of their screen. This will then display the level of care required to provide care as directed in their care plan including 2 person assistance. On 4-10-25, DON/designees audited residents' Kardex to ensure the level of required assistance was stated as directed by resident's care plan. 13 residents were identified as needing 2-person assistance for bed mobility. On 4-10-25, DON/designees audited employee roster to ensure 100% of direct care nursing staff (full-time, part-time, and PRN) are in-serviced to refer to the Kardex for the level of assistance: including 2 person assistance required by residents with ADL care. The training regarding to refer the Kardex for the level of assistance: including 2 person assistance required to provide ADL care will be ongoing. Continuous training to be conducted during the orientation of newly hired direct care nursing staff (full-time, part-time, and PRN). The DON/designees provide oversight and ensure compliance. No direct care nursing staff will be allowed to work without receiving the in-service on the utilization of the residents' Kardex to determine the level of assistance that is required to provide care. DON/designees will conduct random direct care observation audit for compliance with the utilization of the Kardex for the level of assistance: including 2 person assistance required by residents with ADL care daily for 1 week, weekly for 1 month and monthly thereafter until compliance is sustained for 3 consecutive months. Noncompliance identified will be corrected immediately. On 4/9/25, the facility Administrator notified the Medical Director via phone. Items discussed were: IJ (Immediate Jeopardy) was cited on 4/9/25 as evidenced by facility's failure to: F656 - Develop and implement a comprehensive person-centered care plan The facility failed to follow Resident # 1's care plan when care was provided by one staff member only. All direct care nursing staff is to identify and utilize the Kardex to review resident's care plan to determine the level of assistance required to provide care. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	All direct care nursing staff will demonstrate and acknowledge that they are aware of how to identify and utilize the Kardex to review resident's care plan to identify the level of assistance required to provide care. The Kardex is in the POC dashboard which is accessible by all direct care nursing staff in the facility. To access the employee will log into their POC, select the resident and then select the Kardex button located on the right-hand side of their screen. This will then display the level of care required to provide care as directed in their care plan. DON/designees audited residents' Kardex to ensure the level of required assistance is stated as directed by resident's care plan. DON/designees audited employee roster to ensure 100% of direct care nursing staff are in-serviced regarding identification and utilization of the Kardex. The training regarding to refer the Kardex for the level of assistance: including 2 person assistance required to provide ADL care will be ongoing. Continuous training to be conducted during the orientation of newly hired direct care nursing staff (full-time, part-time, and PRN). The DON/designees provide oversight and ensure compliance No direct care nursing staff will be allowed to work without receiving the in-service on the utilization of the residents' Kardex to determine the level of assistance that is required to provide care. Random direct care observation audit will be conducted by DON/designees for compliance with the utilization of the Kardex to determine the level of assistance that is required to provide care to the residents daily for 1 week, weekly for 1 month and monthly thereafter until compliance is sustained for 3 consecutive months. Noncompliance identified will be corrected immediately. This will be reviewed monthly in QAPI until sustained compliance is achieved. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 4/09/2025 with the Medical Director. The Medical Director has reviewed and agrees with this plan. While the IJ was removed on 04/10/25 at 7:10 pm, the facility remained out of compliance at a level of no actual harm at a scope of widespread because the facility's need to evaluate the effectiveness of the corrective systems. Monitoring: Record review completed on 04/10/25 of inservice dated 04/09/25 by clinical services director - refer to Kardex on level of assistance required by residents with ADL care including residents that require a 2 person assist, signed by the DON. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review completed on 04/10/25 of log dated 04/09/25 used to complete training for staff, indicated who was trained over the phone or in person. Of 77 direct care staff, 75 were inserviced which is 97 percent. 2 which have not are PRN staff not scheduled to work, but per the clinical services director, they will be inserviced when they are scheduled prior to their shift. During interviews on 04/10/25 from 12:40 pm - 3:20 pm, two LVNs, one MA, and 9 CNAs from different shifts all stated they were in-serviced before working their shift on utilization of the residents' Kardex to determine the level of assistance that is required to provide care and observed the CNA's ability to locate the Kardex and care requirements for ADLS and transfers. Record review completed on 04/10/25 of in-service dated 03/27/25 at 9:00 am presented by Administrator to CNA A you must refer to the Kardex prior to providing assistance to residents so that you can ensure you are providing the appropriate level of care. Observed signature by CNA A. Record review completed on 04/10/25 of audit done on all residents dated 04/10/25 for bed mobility and level of assist and Kardex accuracy. Audit was completed of all residents, of 15 that had a x2 status- 2 were corrected which no longer required x2 assistance and changed to x1 assist, condition improved. Record review completed on 04/10/25 of audit of employee rooster to ensure 100% of direct care (full-time, part-time, and PRN) were in-serviced to refer to the Kardex for the level of assistance: including 2 person assistance required by residents with ADL care. Record review completed on 04/10/25 of adhoc QAPI dated 04/09/25 with sign in sheet that included 7 staff; Administrator, Regional VP of Ops, DON, ADON E, ADON F, Clinical Services Director, and facility MD. While the IJ was removed on 04/10/25 at 7:10 pm, the facility remained out of compliance at a level of no actual harm at a scope of widespread because the facility's need to evaluate the effectiveness of the corrective systems.

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Accel at College Station	1500 Medical Avenue College Station, TX 77845

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46708 Based on observation, interview, and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of six residents reviewed for accidents and hazards, in that: The facility failed to protect Resident #1, who required a two person assist for toilet, transfers, bed mobility and bathing, when CNA A, acting alone on 03/26/2025, assisted Resident #1 with ADL care. Resident #1 slid off her bed, sustained a severe laceration (a tear or cut in the skin or other tissues caused by trauma) to her right hip and a fracture to her left hip. An IJ was identified on 04/09/25. The IJ template was provided to the facility on [DATE] at 5:36 pm. While the IJ was removed on 04/09/25, the facility remained at a level of no actual harm at a scope of isolated that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. This failure placed residents at risk for negligence, injury, and hospitalization . Findings included: Review of Resident #1's face sheet, dated 04/09/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE], readmitted on [DATE] and 07/07/23 with diagnoses including Congestive heart failure (a condition where the heart can't pump enough blood to meet the body's needs, leading to fluid buildup in the body, particularly in the lungs and extremities), varicose veins (swollen, twisted, and enlarged veins, usually seen on the legs), and body mass index BMI 45.0 - 49.9 (indicates Class III obesity, also known as morbid obesity). Review of Resident #1's quarterly MDS assessment, dated 01/27/25, reflected a BIMS of 15, indicating resident had intact cognition. Review of Resident #1's quarterly care plan, revised on 11/24/21, reflected ADL performance deficit related to immobility, pain, and poor vision with interventions of Toilet use - Resident #1 required (X2) staff participation to use toilet revised on 11/24/21. Transfer - Resident #1 required (X2) staff participation with transfers revised on 11/24/21. Bed Mobility - Resident #1 required (X2) staff participation to reposition and turn in bed revised on 11/24/21. Bathing - Resident #1 required (X2) participation with bathing revised on 11/24/21. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #1's hospital HPI dated 03/26/25 reflected Resident #1 presented to the ER after a fall. Resident lived at a nursing home and reportedly, when they were changing the sheets she fell out of bed . In the ER she was found to have a left comminuted intertrochanteric fracture (a break in the femur (thigh bone) that occurs in the intertrochanteric region, specifically between the greater and lesser trochanters. This fracture type was often seen in older adults and can result from a fall or impact. The comminuted aspect means the fracture has multiple bone fragments making it a more unstable fracture) and a large V-shaped skin tear that was stabled in the ER. A review of the Texas Unified Licensure Information Portal for the facility revealed that on 03/26/25 the facility reported that on 03/26/25 CNA A was administering ADL care to Resident #1 and rolled her to her right side. Resident #1 slid out of bed onto the floor. Resident #1 received a laceration to her right lower extremity and was sent to the emergency room . The facility later received notification that Resident #1 had a left hip fracture. Review of unsigned facility statement from CNA A dated 03/26/25 reflected, I [CNA A] was giving [Resident #1] a bed bath, when I turned her over to clean the other side of her, she slid out of her bed on to the Floor. I ran fast to tell nurse. we came back with help to get her off the floor. her legs were bleeding bad, so the nurse called 911, the nurses wrapped her legs to slow some of the bleeding. By then the paramedics/EMT Came and took her to the hospital. A review of Resident #1's Progress Note dated 03/26/25 by LVN B reflected he was called to Resident #1's room by staff and found resident on floor at bedside closest to window. Resident #1 was nude from ADL care and her lower extremities lay across the legs of the bedside table, while her head was partially resting against wheels of bed. Resident #1 was alert and oriented and able to converse about her condition. After returning resident to bed with assistance of staff and mechanical lift it was determined that the laceration on the upper part of right thigh required a physician's intervention. While additional staff nurses remained with resident to help control bleeding RN B returned to desk and called EMS and reported to hospital ER of impending transfer. Resident was transferred to [hospital] by EMS, MD was made aware, and DON was informed. Resident #1 was her own responsible party and concurred with the treatment plan. Review of facility statement by the Administrator dated 03/27/25 9:15 am revealed she spoke with CNA A regarding the incident with Resident #1 and asked if she knew how to read the Kardex (a concise nursing documentation system that summarizes key patient information, including medications, treatments, and daily care plans) and CNA said she did. Administrator asked her if she read it the morning of the incident with Resident #1 and CNA A said she did not. The Administrator asked CNA A how many people it took to assist Resident #1 and with peri care (cleaning the genital and anal areas to maintain hygiene and prevent infections) as well as other ADL's and CNA A said 2 (two). The Administrator asked CNA A if she used another person to assist Resident #1 and CNA A replied no, that the other aides were assisting other residents. The Administrator revealed she educated CNA A on the importance of reading the Kardex as well as following the Kardex and that it was to prevent any injuries to the resident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of facility statement by the Administrator dated 03/27/25 9:15 am revealed she asked CNA A to go to Resident #1's room and show her how the incident occurred. The Administrator said CNA A raised the bed to the position it was at the time of the incident and CNA A stated that when she got ready to turn [Resident #1] she pulled the sheet up and turned [Resident #1] on her right side. This was when [Resident #1's] left leg swung over the side of the bed causing [Resident #1] to slide off the bed landing on her stomach. [Resident #1's] head was by the front wheels of the bed and her legs were by the back wheels of the bed. [CNA A] stated that [Resident #1's] lower right leg was laying, on the top of the bottom of the over the bed table. This table has a metal frame that holds the table with the bottom of the bedside table where [Resident #1's] right lower extremity landed. CNA A told the Administrator that there was blood at the bottom of the bedside table where [Resident #1's] right lower extremity landed. The Administrator said she asked if Resident #1 complained of pain to either of her hips and CNA A stated that [Resident #1] did not. Review of signed statement dated 03/26/25 of CNA C who stated I was sitting at the nurse's station when we were approached by [RN B] to assist with [Resident #1] that fell out of bed. I went to assist with the fall of [Resident #1]. I came to help get [Resident #1] off the floor. Review of signed statement dated 03/26/25 of CNA D who stated, I was sitting at the nurse's station when we were approached by [RN B] to assist with [Resident #1] that fell out of bed. I went to assist with the fall of [Resident #1]. I came and grabbed the [mechanical lift] to help assist until no longer needed. Attempted interview on 04/09/25 with Resident #1, who discharged to another facility from the hospital after the incident, at 11:42 am reflected, when phoning Resident #1, received a voice mail that the number requested could not be dialed and unable to interview Resident #1. Interview on 04/09/25 with a Family Member of Resident #1 at 11:25 am who stated Resident #1 no longer had a telephone. Family Member reported the facility staff, rolled [Resident #1] right off the bed. The Family member said there was a policy in place for Resident #1 to have 2 (two) people always go in and assist Resident #1 when she needed to be changed. The Family member reported Resident #1 had, 30 staples and 7 stitches and a broken hip. An interview on 04/09/25 with CNA A at 12:36 pm she stated she felt like the facility was short staffed and she did not want to bother the other staff and ask for help. She said she had helped Resident #1 alone previously and Resident #1 had been sitting in urine and needed to be changed . CNA A said she did not purposely hurt Resident #1, but she did not ask for help to assist Resident #1 with ADL care. She said she had not been asked to return to work at the facility since the incident. CNA A said when Resident #1 fell , she ran to get a nurse and he assisted with getting Resident #1 off the floor, using a mechanical assistive devise. CNA A stated she was not trained on how to use the Kardex but did know that Resident #1 was a 2 (two) person assist when changing or moving Resident #1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A phone call interview on 04/10/25 with LVN B at 2:12 pm revealed he was the nurse on shift at time of Resident #1's fall on 03/26/25 and, to his knowledge the resident was a 2 (two) person assist. He said the Kardex contained information about Resident #1's ADLs and transfer status. LVN B stated the CNAs referred to the Kardex to determine the care needs of a resident and the Kardex was available to all CNAs. LVN B stated, he was not aware, at the time of the incident, that CNA A was providing care alone. LVN B stated he was informed by staff (staff name unknown) that Resident #1 had a large bowl movement and CNA A wanted to bath her after but stated that CNA A should have gotten help and that there was plenty of staff that night to assist and no reason for her to not ask for help. CNA B revealed, Why she chose not to do that I don't know, I was at the nurses station charting when she came to get me for help. He stated if CNA A had told him that she was going to provide ADL assistance for going to bathe Resident #1 he would have gotten up to help CNA A, but she did not inform him that she needed a second staff member to help her with Resident #1. He stated he was the charge nurse that night. He stated the caregiver was ultimately responsible to ask for assistance with residents because they knew the rules when they were given their assignments. LVN B stated anyone would be crazy to take a resident her size on by themselves and he did not know why to this day CNA A did not ask for help. LVN B recalled the resident's weight to be in the area of 260 plus pounds. Resident #1 was in a bariatric bed, and it was hard for LVN B to imagine that someone would attempt changing and cleaning her alone. When LVN B walked into the room to help after CNA A called him, he said it looked like she [CNA A] was getting ready to change the oil on the bed- that was never safe at any time for any patient especially someone with Resident #1's weight to have a bed that high. The aide should have gotten help, the call light was available and there was always a way to get help. An interview on 04/10/25 with CNA C at 2:33 pm revealed she was at the nurses' station on the rehabilitation side of the facility when LVN B came to get her stating they needed help getting a resident off the floor. CNA C stated she saw the resident on the floor in between the wall and the bed and Resident #1's bed was pretty high up. CNA C stated prior to this event, she never worked with Resident #1 but upon seeing Resident #1, because of Resident #1 was a big woman, she would have known that Resident #1 was a 2 (two) person assist. CNA C stated that the number of staff assistance a resident was required for safe resident care and the information was in the Kardex located in EMR. A CNA could click on the Kardex to see if the resident was a one or two person assist. CNA C said if there was not another person to assist a resident who was a 2 (two) person assist, she would ask a nurse to help or wait for a coworker to get help before assisting the resident. She said she did not recall how many staff members were working that night but said there were plenty of people listing herself, two aides, a nurse, and a nurse trainee. CNA C stated that CNA A could have also asked the people in the rehabilitation side of the facility for help. CNA C stated it was never appropriate to proceed with just one person if the resident was listed in the Kardex as a 2 (two) person assist. If the Kardex says the Resident require a 2 (two) person assist, you wait until you have 2 (two) people to assist. CNA C stated, you never know the condition or if they just had hip surgery, you always wait to have the amount of people you need. CNA C stated she has no idea why the CNA A did not ask for help that night. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A phone interview on 04/10/25 with CNA D at 2:50 pm revealed LVN B asked for help with a resident. CNA D stated she walked into Resident #1's room and saw Resident #1 on the floor and she went to grab the mechanical lift to lift help get Resident #1 off the floor. CNA D stated they needed a mechanical lift due to Resident#1's size and also because of Resident #1's ADL abilities. CNA D stated she had worked with Resident #1 in the past and stated it was very obvious for anyone, even working with Resident #1 for the first time, to see that Resident #1 was a 2 (two) person assist based on her size and appearance. CNA D stated she would look at the Kardex to determine the level of assistance needed for residents. CNA D stated if she did not have the 2nd person needed to assist a resident, she would go find help and stated, you just have to ask for help. CNA D stated it was never appropriate to proceed to assist without the help of others if they require 2 (two) or more even assist if it appeared manageable. CNA D stated it was everyone's responsibility to ensure the residents received the level of care they need. She stated she referred to the Kardex daily because something could change. She stated she would report any Kardex issues to her nurse or the Administrator as needed. An interview on 04/10/25 with ADON at 6:02 pm stated stated CNAs were ultimately responsible for ensuring the correct level of care for residents because they were trained and knew the procedures. She stated that agency and PRN staff also have access to the Kardex. She stated she was responsible for the PRN and new hire staff be aware of where to locate the Kardex which displays the care needs of the residents. She stated it was her expectation that they provided the highest level of care, that all residents needs were met in a safe, respectful, and dignified manner. The ADON stated that level of resident care and resident transfer status understanding was the knowledge that kept patients safe. She said that if staff knew the level of resident care needs it helped to makes sure residents remained safe. She stated that if the person was aware of the ADL transfer status of a resident and did not follow the resident ADL transfer status when providing resident care she would consider it negligence because they did not provide the safest level of care. An interview on 04/10/25 with the DON at 6:20 pm revealed she had been the DON at the facility for a week and a half and it was her expectation that the CNAs follow the Kardex that they have been trained to follow. She stated she would consider it negligence if a CNA knew the ADL transfer status of a resident and failed to follow it and stated that CNA would require retraining. DON stated that training for Kardex occurred frequently. An interview on 04/10/25 with the Administrator at 2:33 pm revealed staff needed to ensure the physical abilities and the level of the ADL care needed for residents when providing assistance. The CNAs can find out if residents require a 1 (one) or 2 (two) person level of assistance by referring to the Kardex. If there was not a 2nd staff member available, they need to wait until a 2nd staff member was available to provide resident care. An interview on 04/10/25 with the Administrator at 6:45 pm revealed it was the CNAs responsibility to ensure they were providing the care the resident required. She stated all PRN staff had access to the Kardex and knew how to locate it. She stated it was important to follow the ADL transfer status due to resident safety as well as staff safety. She stated that when she asked CNA A why she didn't ask for help CNA A said that other CNAs were busy, and Resident #1 was impatient. Review of facility Falls and Fall Risk, Managing Policy dated April 2007 reflected based on previous evaluations and current data, the staff will identify interventions related to the resident specific risks and causes to try to prevent resident from falling and try to minimize complications from falling. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility Falls - Clinical Protocol dated April 2007 based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. Review of the facility Abuse and Neglect - Clinical Protocol Assessment and Recognition policy dated April 2007 reflected neglect means failure to provide good and services necessary to avoid physical harm, mental anguish, or mental illness. Treatment/Management -The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The ADM was notified on 04/09/25 at 5:36 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 04/10/25 at 2:27 pm: The POR included the following: F- 600 IJ Template provided to entity: 04/09/25 5:36pm F-600 Plan of Removal Date: April 9, 2025 The Texas Department of Health and Human Services entered the facility on April 9, 2025, for a Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited regarding F600 -The resident has the right to be free from neglect . The facility failed to ensure Resident #1 had two staff members assisting her during care as outlined in Resident #1's care plan. What corrective actions have been implemented for the identified residents? A. On 3/26/2025 Resident #1 involved in alleged deficient practice was discharged to the hospital resident did not return to the facility. B. On 3/26/2025 CNA A was in-serviced on Referring to the Kardex for the level of assistance required by residents with ADL care and the Abuse and Neglect Policy by the administrator. C. On 3/26/025 CNA A was suspended on 3/26/2025 pending investigation findings. D. On 4/09/2025 at 7:20 pm the Administrator notified the Medical Director of the alleged deficient practice. Record review completed on 04/10/25 of screenshot showing call made to the MD 04/09/25 at 7:20 pm. E. CNA A last day employed was on 3/31/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	F. On 4/09/2025 the Corporate Clinical Service Director re-educated the nurse management team on referring to the Kardex for the level of assistance required with ADL care including residents needing 2-person assistance and the Abuse and Neglect Policy. The completion date was 4/09/2025. G. On 4/09/2025 the Administrator and Nurse Managers re-educated the nursing staff on referring to the Kardex for the level of assistance required with ADL care including residents needing 2-person assistance and the Abuse and Neglect Policy. The completion date was 4/10/2025. H. On 4/10/2025 an audit was conducted by the Corporate Clinical Service Director and the nurse management team to ensure the level of ADL care required, including residents needing 2-person assistance was noted in the Kardex. There were 13 residents identified that require 2-person assistance with bed mobility. Discrepancies found were immediately corrected on 04/10/2025. I. The Corporate Clinical Service Director reviewed facility policy on 04/09/2025 regarding change in condition and no revisions were deemed necessary. How were other residents at risk to be affected by this deficient practice identified? A. All residents have the potential to be affected by the alleged deficient practice. On 4/10/2025 the Regional Nurse completed Resident Life Satisfactory Surveys for residents that require 2-person assistance, no concerns were noted. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. On 4/09/2025 the nurse management team re-educated the nursing staff (Full-time, Part-time, and PRN) on referring to the Kardex for the level of assistance required, including residents needing 2-person assistance with ADL care and the Abuse and Neglect Policy. Nursing staff will not be allowed to return to work until they receive this in-service. The completion date was 4/10/2025. B. Newly hired nursing staff will be in-serviced upon hire during staff orientation by nurse management/designee on referring to the Kardex for the level of assistance required, including residents needing 2-person assistance with ADL care and the Abuse and Neglect Policy. C. DNS /designee will conduct random observations of ADL care including residents needing 2-person assistance is being provided daily for one week, then weekly for one month, and monthly thereafter until compliance is sustained for three consecutive months. Noncompliance identified will be addressed immediately. How will the system be monitored to ensure compliance? A. The ADONs will review the change in condition daily x 3 months for any changes in residents' ADL level of assistance requirements and ensure the Kardex is updated as applicable. Discrepancies noted during reviews will be immediately corrected. Further training will be provided as identified by the nurse manager who identified the discrepancy when and if necessary. The review will be documented on an audit report form. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review completed on 04/10/25 of audit done on all residents dated 04/10/25 for bed mobility and level of assist for Kardex accuracy. Audit was completed of all residents, of 15 that had a x2 status- 2 were corrected which no longer required x2 assistance and changed to x1 assist, condition improved. Record review completed on 04/10/25 of the in-serviced dated 04/09/25 on re-education of the nursing staff on referring to the Kardex for the level of assistance required with ADL care including residents needing 2-person assistance and the Abuse and Neglect Policy. Record review completed on 04/10/25 of adhoc QAPI dated 04/09/25 with sign in sheet that included 7 staff; Administrator, Regional VP of Ops , DON, both ADONs, Clinical Services Director, and facility MD. While the IJ was removed on 04/10/25 at 7:10 pm, the facility remained out of compliance at a level of no actual harm at a scope of widespread because the facility's need to evaluate the effectiveness of the corrective systems.