STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Patriot Rehabilitation and Wellness Center	11490 Gateway North Blvd. El Paso, TX 79934

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46998 Based on observation, interviews and record review, the facility failed to ensure residents the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Residents #5) of 5 residents reviewed for call light button placement and 2 (Hall 300 and Hall 400) of 4 hallways reviewed for call light response. The facility failed to ensure that Residents #5's call light was within reach on 12/10/24 and on 12/11/24, while he was in bed. It was observed on 12/11/24, in Hall 300, room [ROOM NUMBER]'s call light was on for 26 minutes while facility staff walked up and down the hallway without entering the resident room. It was observed on 12/11/24, in Hall 300, Room call light was on for 21 minutes while facility staff walked up and down the hallway without entering the resident room. It was observed on 12/11/24, in Hall 400, room [ROOM NUMBER]'s call light was on for 31 minutes while no facility staff was seen in the hallway. This failure put residents at risk of not being able to call for assistance when needed and injury. Findings included: Resident #5 Record review of Resident #5's face sheet dated 12/10/24, reveled, admission on 01/10/24 and re-admission on 11/06/24 to the facility diagnosed with muscle weakness, muscle wasting, lack of coordination, cognitive communication deficit, and repeated falls. Record review of Resident #5's facility history and physical dated 11/06/24, revealed, a [AGE] year-old male diagnosed with Alzheimer Dementia and benign prostatic hypertrophy. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's quarterly MDS dated [DATE], revealed, there was no BIMS score taken to measure the recall or daily cognition of the resident. Functional abilities revealed substantial/maximal assistance (Nursing staff does more than half the work) for rolling left or right in bed, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed and bed to chair, and toilet transfer. Record review of Resident #5's care plan dated 01/10/24, revealed, the resident had impaired thought process related to Alzheimer's Dementia. Provide me with a homelike environment. At risk of falls related to unaware of safety needs. Be sure call light was within reach and encourage me to use it for assistance as needed. Follow facility fall protocol. I need a safe environment free from clutter, a reachable call light. Floor mat beside my bed at all times when I'm in bed. ADLs requires extensive assistance x2 staff to turn and reposition when in bed for bed mobility. During an interview on 12/10/24 at 11:03 AM, CNA F stated the call lights have to be within a reach of a resident. CNA F stated CNAs and nurses were responsible for ensuring the call lights were within reach of the resident. CNA F stated if the call light was not within reach and it was an emergency then the resident would not be able to call for help. During an observation and interview on 12/10/24 at 2:00 PM, with Resident #5 and CNA B, Resident #5 was in his bed awake. Resident #5's call light was on the floor near his nightstand, 2 feet away from the resident. CNA B stated anytime the residents were in bed or in the room, the call light had to be within reach in case the resident needed something or in an emergency. CNA B stated not having the call light within reach the staff would not know what he wanted or in case of an emergency. CNA B extended the call light which touched the top left-hand corner of the bed where his pillow was. It was not long enough to reach Resident #5 while in bed. CNA B stated it needed to be longer. CNA B stated it was the responsibility of the CNAs to ensure that the call light was within reach. During an interview on 12/10/24 at 2:19 PM, DON stated the call lights were to be within reach of the resident. The DON it was for the resident(s) to be able to call for help. The DON stated all staff were responsible for ensuring the call lights were within the residents' reach. The DON stated the risk of not having within the call light within reach was the resident would not be able to call for help. During an observation and interview on 12/11/24 at 8:12 AM, with Resident #5 and LVN C. Resident #5's call light was on the floor. Resident #5 was in bed awake. Resident #5 when asked questions made some vocal sounds and moved his hands. LVN C stated the call light had to be within reach of Resident #5 and all the residents when in their rooms. LVN C stated the risk of not having the call light within reach would be the resident needing something. Hallway 300 During an observation on 12/11/24 at 2:22 PM, in Hall 300, room [ROOM NUMBER]'s call light was on for 21 minutes while facility staff walked up and down the hallway without entering the resident room. Facility staff was observed going into the room and turning off the call light at 2:43 PM. During an observation on 12/11/24 at 2:28 PM, in Hall 300, room [ROOM NUMBER]'s call light was on for 26 minutes while facility staff walked up and down the hallway without entering the resident room. Facility staff was observed going into the room and turning off the call light at 2:54 PM. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hallway 400 During an observation on 12/11/24 at 2:12 PM, in Hall 400, room [ROOM NUMBER]'s call light was on for 31 minutes while no facility staff was seen in the hallway. At 2:43 PM, facility staff went into the room and call light was turned off. During a follow-up interview on 12/12/24 at 10:52 AM, DON stated if a call light was turned on then the staff should be responsible as soon as possible. The DON stated the call lights should not be on no more than 30 minutes or an hour being considered unacceptable. The DON stated the resident could get agitated if they needed assistance and their needs would not be getting met. The DON stated the negative outcome would be their needs not getting met and agitation. The DON stated staff have been trained to respond to call lights and anyone can answer them. The DON stated there was not process during shift change when reports were being given to see who will be responding to the call lights. The DON stated it would definitely help if there was one. Record review of the facility Call Lights: Accessibility and Timely Response policy not dated, revealed, Policy: The policy of this policy was to assure the facility was adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. All staff will be educated on ensuring resident access to the call light. Staff will ensure the call light was within reach of the resident and secured as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. All staff members who see or hear an activated call light are responsible for responding. Record review of the facility Resident Rights policy not dated, revealed, Policy: The facility will inform the resident both orally and in writing, in language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers, are educated on the rights of residents and the responsibility of the facility to properly care for its residents.

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F 0604

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46998

Based on the observation, interview, and record review, the facility failed to ensure residents had the right to be treated with respect and dignity, including the right to be free from any physical restraints imposed for purpose of discipline or convenicence, and not reuqired to treat the residnet's medical symptoms for 2 (Resident #4 and Residnet #5) of 5 residents reviewed for physical restraints.

The facility failed to ensure Resident #4 and Resident #5 were not restrained in bed by use of a fall mat being propped up next to the bed being held in place by faciliy furniture.

This failure could place residents at risk of unnecessary restriction of their freedom of movement, decrease quality of life, injury, suffocation, and falling.

Findings include:

Resident #4

Record review of Resident #4's face sheet dated 12/11/24, revealed, admission on 11/16/24 to the facility. Resident #4 was a [AGE] year-old female diagnosed with Dementia, muscle weakness (reduced muscle strength) muscle wasting (decrease in size and wasting of muscle tissue), attention (inattention (not being able to keep focus)) and concentration deficit (having trouble focusing your mind on a task for a sustained period of time), and cognitive deficit (someone has trouble thinking clearly, remembering things, making decisions, or understanding information).

Record review of Resident #4's admission MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 3 to be able to recall or make daily decisions. Functional abilities revealed substantial/maximal assistance (Nursing staff does more than half the work) for rolling left or right in bed, sit to lying, lying to sitting on side of bed. Resident #4 was dependent (nursing staff does all the work) for sit to stand and chair to bed to chair transfer.

Record review of Resident #4's Order Recap dated 11/16/24, revealed, admitted to Skilled Services at facility due to Right femur fracture and traumatic hemorrhage of left cerebrum with loss of consciousness.'

Record review of Resident #4's Fall Risk Assessment generated by RN A dated 11/16/24, revealed, HIGH RISK. Level of consciousness/mental status was coded a 2 for Disoriented x3 (indicates that a patient was aware of three key aspects: who they are (person), where they are (place), and when it was (time) at all times. History of Falls (pasted 3 months) coded for 2 for 1-2 falls in pasted 3 months.

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Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's care plan dated 11/18/24, revealed, ADLs for bed mobility/transfers requiring assistances to maximize independence with turning and repositioning in bed. Had impaired cognitive function/dementia or impaired thought processes. Cue, reorient, and supervise as needed. At risk for falls related to dementia and history of falls. Follow facility fall protocol. Has a mood problem. Has impaired judgment or safety awareness. observation of a photo of Resident #4 provided to state agency by unknown person not dated was reviewed on 12/09/24, revealed, Resident #4 was in bed lying on her rights side with her legs curled up against the blue fall mat. Resident #4 had her right arm up and her right hand over her eyes with her mouth open. Right hand was touching the blue fall mat. On the left side of the Resident #4's body were pillows, yellow blankets between the mattress and bar rail, and blankets rolled up and placed on her left side bed underneath the white sheet. The left side bed was close to the wall. On the other side 2 folded up blue fall mats were placed sideways standing up against Resident #4's bed with a chair and a nightstand pushed up against the 2 folded up blue mats. During an interview on 12/11/24 at 4:15 PM, CNA K stated he walked into Resident #4's room on11/16/24 and saw the blue fall mat with a chair pushed up against it against Resident #4's bed while she was in it. CNA K stated he had only seen her and no other resident like this before. CNA K stated he immediately took down the fall mat and moved the chair. CNA K stated he had alerted LVN M about this and she had stated the fall mat against the Resident #4's bed pushed up against it by a chair was not supposed to happen as it was a restriction and considered a restraint. CNA K stated LVN M got up and went to check on Resident #4. CNA K stated he had not seen another fall mat placed against the resident's bed and the furniture pushed up against other than Resident #4. CNA K stated it did not look appropriate to him and that's why I took it down. CNA K stated CNA K stated this happened the first day she was admitted because she was too fidgety and tended to get up. CNA K stated restraints were not allowed but was not sure if it was a restraint. CNA K stated it could be seen as a restraint. CNA K stated the resident was at risk from falling off the bed. CNA K stated when he removed the fall mat and chair, Resident #4 was asleep in the bed. During a telephone interview on 12/11/24 at 3:05 PM, LVN E stated she was the Weekend Supervisor working from 6AM-10PM. LVN E stated the fall mat was not used from preventing Resident #4 from getting out of bed. LVN E stated nurses do have it as an intervention for falls for residents' safety. LVN E stated chairs or other furniture could not be placed. LVN E stated resident safety comes first. LVN E stated her and LVN M used the fall mat as a precaution because Resident #4 was being combative. LVN E stated they put the fall mat in place for about 10-15 minutes while they got another bed to switch out that would lower down in position. LVN E stated it was on her admission on 11/16/24. LVN E stated Resident #4 was a high risk for falls. LVN E stated that the bed mattress was placed on the floor along with Resident #4 who was laid on top of it, while they switched out the bed. LVN E stated it would not be appropriate placing a fall mat against the resident's bed with furniture pushed up against it. LVN E stated it would be considered a restraint. LVN E stated when they applied it and the way they had used it was used as an intervention to Resident #4 from falling. LVN E stated it was not done on any other residents. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 12/12/24 at 11:15 AM, LVN E stated Resident #4 was combative and as per policy they could use the fall mat as an intervention as the least restrictive. LVN E stated Resident #4's bed was placed to the corner next to the wall near the bathroom. LVN E stated the bed rail created a gap between the bed and the wall and thought Resident #4 might have a fall in between the gap. LVN E placed pillows and blankets to keep Resident #4 from falling on the right side of the bed closet to the wall and on the other side a fall mat was placed leaning against Resident #4's bed. LVN E stated Resident #4 was able to yell out and move and LVN M and her did not tie her down. LVN E stated this took around 10 minutes while they got the other bed and conducted the switch of beds for Resident #4. LVN E stated Resident #4 was not along and had LVN M (the Floor Nurse for that hallway)in the room with CNA J working in and out of the room. LVN E stated it was an intervention for Resident #4. During an interview on 12/11/24 at 4:34 PM, LVN M stated residents nor staff have reported to her staff placing fall mats against residents' beds with furniture pushed up against them. LVN M stated that was not appropriate as it was a restraint. LVN M stated Resident #4 during admission was impulsive and wanted to dance. LVN M stated Resident #4 was a high fall risk. LVN M stated Resident #4's bed was not changed out that day. LVN M stated her and LVN E did not place Resident #4 on the floor on top of her mattress. LVN M stated she had no reason to do that, and the facility staff know this. LVN E stated it was a dignity issue. LVN M stated she had not seen a fall mat placed against Resident #4's bed with furniture pushed up against it. LVN M stated she had been trained on Restraints and would consider it a restraint. During an interview on 12/11/24 at 4:28 PM, with CNA J, he stated he worked on 11/16/24 and 11/23/24 on the weekend. CNA J stated he had not seen nor heard from staff or /residents saying staff were placing fall mats against residents' beds with furniture pushed up against it. CNA J stated this would not be right and would be a restraint. CNA J stated he had been trained on Abuse, Neglect, and Exploitation and Restraints. During an interview on 12/10/24 at 2:19 PM, the DON stated she had not seen fall mats being placed against resident beds and held up by furniture. The DON stated that would be inappropriate and would be considered a restraint. The DON stated when Resident #4 got to the facility she was very anxious, but it would not warrant having the fall mats placed against the bed with furniture propped up against it. During an interview on 12/10/24 at 2:42 PM, the Administrator stated no one had reported to him that a fall mat or nursing tray tables were being placed against the bed of a resident who was on the bed. The Administrator stated if the staff did that, he would think it was to prevent a fall. The Administrator stated he would think there would be better ways like placing the bed in the lowest position instead of placing the fall mat against the bed with furniture push up against the fall mat. The Administrator stated he would consider it a restraint at the minimum. The Administrator stated this was not acceptable practice and not acceptable because the facility has better interventions. During an interview on 12/11/24 at 8:20 AM, Resident #4, stated she did not remember anything. Resident #4 looked downwards and did not say anything else. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/12/24 at 8:35 AM, the DOR stated Resident #4 was weak. The DOR stated Resident #4 for bed mobility was max to moderate assistance to max assistance. The DOR stated if a fall mat was placed against the resident's bed and had furniture up against it then Resident #4 might not be strong enough to move it out of the way. The DOR stated it would be a hazard. During an interview on 12/12/24 at 8:58 AM, NP D stated Resident #4 was a high risk for falls. NP D stated it had not been reported to him that the fall mats were being used to be placed against Resident #4's bed and had furniture pushed up against it. NP D stated the fall mat would be used as an intervention to prevent falls but would have to be laid on the floor next to the resident's bed. NP D stated having the fall mat pushed up against the resident's bed with furniture propped up against it was not allowed to happen. NP D stated he had never seen that before and was a risk as it was obstacle to the resident. NP D stated he was going to talk to the facility MD regarding the allegation as it was concerning. NP D stated Resident #4 might be able to move the objects out of the way. Resident #5 Record review of Resident #5's face sheet dated 12/10/24, reveled, admission on 01/10/24 and re-admission on 11/06/24 to the facility diagnosed with muscle weakness, muscle wasting, lack of coordination, cognitive communication deficit, and repeated falls. Record review of Resident #5's facility history and physical dated 11/06/24, revealed, a [AGE] year-old male diagnosed with Alzheimer Dementia and benign prostatic hypertrophy. Record review of Resident #5's quarterly MDS dated [DATE], revealed, there was no BIMS score taken to measure the recall or daily cognition of the resident. Functional abilities revealed substantial/maximal assistance (Nursing staff does more than half the work) for rolling left or right in bed, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed and bed to chair, and toilet transfer. Record review of Resident #5's care plan dated 01/10/24, revealed, had swallowing problem and at risk for aspiration, aspiration pneumonia and upper respiratory infections. Maintain HOB elevated to 30-45 degrees angle during feedings. Had impaired thought process related to Alzheimer's Dementia. Provide me with a homelike environment. At risk of falls related to unaware of safety needs. Be sure call light was within reach and encourage me to use it for assistance as needed. Follow facility fall protocol. I need a safe environment free from clutter, a reachable call light. Floor mat beside my bed at all times when I'm in bed. ADLs requires extensive assistance x2 staff to turn and reposition when in bed for bed mobility. Observation of a photo of Resident #5 provided to state agency by unknown person not dated but reviewed on 12/09/24, revealed, Resident #5 was in bed lying on his back with his left hand up. To the right side of Resident #5 was a blue fall mat placed sideways standing up against his bed, while on the left side of the bed was the room wall. Pushed up against the blue fall mat was a chair and a nurse's tray table. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/10/24 at 2:00 PM, with Resident #5 and CNA B. Resident #5 was in his bed awake. Resident #5 did not have a fall mat placed next to his bed. When Resident #5 was asked questions, he would just look and move his hands. CNA B stated when Resident #5 was in bed that the fall mat should be placed in case, he had a fall to prevent an injury. CNA B stated it was the responsibility of the CNAs to ensure the fall mat was placed. During an interview on 12/10/24 at 2:19 PM, the DON stated the fall mat against Resident #5's bed pushed against by furniture was inappropriate. The DON stated she considered it a restraint. The DON stated Resident #5 was a high fall risk and his mat should be placed on the floor next to his bed. The DON stated staff understood they should not be doing that. During a follow-up interview on 12/12/24 at 11:15 AM, LVN E stated she would not know why anyone would place a fall mat against Resident #5's bed with furniture pushed against it. During a follow up interview on 12/12/24 at 8:35 AM, the DOR stated Resident #5 had been on case load for therapy. The DOR stated Resident #5 was total dependence (nursing staff assist with total assistance) for ADLs . The DOR stated Resident #5 was fidgety (constantly making small, restless movements with your body). The DOR stated if a fall mat was placed against the resident's bed and had furniture up against it then Resident #5 would not be able to move it out of the way because he was not strong enough to be able too. DOR stated it would be a hazard. During an interview on 12/12/24 at 8:58 AM NP D stated Resident #5 was very confused but managed to get out of bed by himself. NP D stated Resident #5 had never been verbal with him. NP D stated if the fall mat was placed against the Resident #5's bed with propped furniture against it then Resident #5 would not have the strength to move the objects out of the way. Record review of the Provider Investigation Report dated 11/25/24, for Resident #4 and Resident #5, revealed, Incident Date: 11/16/24. Description of allegation: On 11/16/24, Resident #4 was admitted to the facility for long term care. Resident #5 has been admitted to the facility since around 2022. On 11/16/24, in the evening, LVN E, restrained resident #4 and Resident #5 in their beds with fall mats held against the bed by furniture. The residents had a rolled-up blanket placed under their fitted sheet to further restrain them. This was reported to the Administrator. LVN E stated this was her solution to prevent providing one to one supervision to the resident who have been Fidgety (jittery, restless, or anxious). On 11/23/24, the residents were restrained in their beds again. Record review of LVN E's Timesheet dated 11/16/24, revealed, LVN E working from 6AM-9:08 PM. On 11/23/24- worked 2:01PM-10:05PM. LVN E was not on any floor schedule as she was the Weekend Supervisor. Record review of LVN M's Timesheet dated 11/16/24, revealed, LVN M working from 6:12 AM-10:50PM. Record review of LVN M's floor schedule dated 11/16/24, revealed, working 100 hall from 6AM to 10PM. On 11/23/24 - worked 100 hall from 6AM to 10PM. Record review of CNA J's Time sheet dated 11/23/24, revealed, CNA J working from 6:06AM-10:08PM. On 11/23/24 - worked 6:09AM-2:03PM. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of CNA J's floor schedule 11/16/24, revealed, working 100 hall from 6AM to 10PM. On 11/23/24- worked 100 hall from 10:15AM-2PM. Record review of CNA K's Timesheet dated 11/16/24, revealed, CNA K working from 6:17AM-10:08PM. On 11/23/24- worked 6:18PM-10:09 PM. Record review of CNA K's floor schedule dated 11/16/24, revealed, working 100 hall from 10:30AM - 7:30 PM. On 11/23/24- worked 100 hall from 10AM to 7PM. Record review of the facility Incidents and Accidents policy noted dated, revealed, Policy: It was the policy of this facility for staff to utilize) specify risk management system/tools used) to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Accident - refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Incident was defined as an occurrence or situation that was not consistent with the routine care of a resident or with the routine operation of the organization. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and or Administrator. Record review of the facility Fall Prevention Program policy not dated, revealed, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Provide additional interventions as directed by the resident's assessment, including but not limited to: Assistive devices.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER: Patriot Rehabilitation and Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 11490 Gateway North Blvd. El Paso, TX 79934	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46998 Based on the observation, interview, and record review, the facility failed to ensure that the residents environment remains free of accidents hazards as possible and each resident receives adequate supervision to prevent accidents for 2 (Resident #4 and Resident #5) of 2 residents reviewed for accidents and supervision. The facility failed to put appropriate fall precautions in place when staff blocked residnets in bed with furniture and fall mats for Resident #4 and Resident #5. Resident #4 was in bed lying on her rights side with her legs curled up against the blue fall mat. Resident #4 had her right arm up and her right hand over her eyes with her mouth open. Right hand was touching the blue fall mat. On the left side of the Resident #4's body were pillows, yellow blankets between the mattress and bar rail, and blankets rolled up and placed on her left side bed underneath the white sheet. The left side bed was close to the wall. On the other side 2 folded up blue fall mats were placed sideways standing up against Resident #4's bed with a chair and a nightstand pushed up against the 2 folded up blue mats. Resident #5 was in bed lying on his back with his left hand up. To the right side of Resident #5 was a blue fall mat placed sideways standing up against his bed, while on the left side of the bed was the room wall. Pushed up against the blue fall mat was a chair and a nurse's tray table. On 12/10/24, It was observed that Resident #4 was lying in bed with no fall mat placed on the floor next to her bed. On 12/10/24, It was observed that Resident #5 was lying down in bed with no fall mat placed on the floor next to his bed. This failure could place residents at risk of decrease quality of life, injury, suffocation, and falling. Findings include: Resident #4 Record review of Resident #4's face sheet dated 12/11/24, revealed, admission on 11/16/24 to the facility. Resident #4 was a [AGE] year-old female diagnosed with Dementia, muscle weakness (reduced muscle strength) muscle wasting (decrease in size and wasting of muscle tissue), attention (inattention (not being able to keep focus)) and concentration deficit (having trouble focusing your mind on a task for a sustained period of time), and cognitive deficit (someone has trouble thinking clearly, remembering things, making decisions, or understanding information). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's admission MDS dated [DATE], revealed, a severely impaired cognition BIMS score of 3 to be able to recall or make daily decisions. Functional abilities revealed substantial/maximal assistance (Nursing staff does more than half the work) for rolling left or right in bed, sit to lying, lying to sitting on side of bed. Resident #4 was dependent (nursing staff does all the work) for sit to stand and chair to bed to chair transfer. Record review of Resident #4's Order Recap dated 11/16/24, revealed, admitted to Skilled Services at facility due to Right femur fracture and traumatic hemorrhage of left cerebrum with loss of consciousness.' Record review of Resident #4's Fall Risk Assessment generated by RN A dated 11/16/24, revealed, HIGH RISK. Level of consciousness/mental status was coded a 2 for Disoriented x3 (indicates that a patient was aware of three key aspects: who they are (person), where they are (place), and when it was (time) at all times. History of Falls (pasted 3 months) coded for 2 for 1-2 falls in pasted 3 months. Record review of Resident #4's care plan dated 11/18/24, revealed, ADLs for bed mobility/transfers requiring assistances to maximize independence with turning and repositioning in bed. Had impaired cognitive function/dementia or impaired thought processes. Cue, reorient, and supervise as needed. At risk for falls related to dementia and history of falls. Follow facility fall protocol. Has a mood problem. Has impaired judgment or safety awareness. observation of a photo of Resident #4 provided to state agency by unknown person not dated was reviewed on 12/09/24, revealed, Resident #4 was in bed lying on her rights side with her legs curled up against the blue fall mat. Resident #4 had her right arm up and her right hand over her eyes with her mouth open. Right hand was touching the blue fall mat. On the left side of the Resident #4's body were pillows, yellow blankets between the mattress and bar rail, and blankets rolled up and placed on her left side bed underneath the white sheet. The left side bed was close to the wall. On the other side 2 folded up blue fall mats were placed sideways standing up against Resident #4's bed with a chair and a nightstand pushed up against the 2 folded up blue mats. During an interview on 12/11/24 at 4:15 PM, CNA K stated he walked into Resident #4's room on11/16/24 and saw the blue fall mat with a chair pushed up against it against Resident #4's bed while she was in it. CNA K stated he had only seen her and no other resident like this before. CNA K stated he immediately took down the fall mat and moved the chair. CNA K stated he had alerted LVN M about this and she had stated the fall mat against the Resident #4's bed pushed up against it by a chair was not supposed to happen as it was a restriction and considered a restraint. CNA K stated LVN M got up and went to check on Resident #4. CNA K stated he had not seen another fall mat placed against the resident's bed and the furniture pushed up against other than Resident #4. CNA K stated it did not look appropriate to him and that's why I took it down. CNA K stated CNA K stated this happened the first day she was admitted because she was too fidgety and tended to get up. CNA K stated restraints were not allowed but was not sure if it was a restraint. CNA K stated it could be seen as a restraint. CNA K stated the resident was at risk from falling off the bed. CNA K stated when he removed the fall mat and chair, Resident #4 was asleep in the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 12/11/24 at 3:05 PM, LVN E stated she was the Weekend Supervisor working from 6AM-10PM. LVN E stated the fall mat was not used from preventing Resident #4 from getting out of bed. LVN E stated nurses do have it as an intervention for falls for residents' safety. LVN E stated chairs or other furniture could not be placed. LVN E stated resident safety comes first. LVN E stated her and LVN M used the fall mat as a precaution because Resident #4 was being combative. LVN E stated they put the fall mat in place for about 10-15 minutes while they got another bed to switch out that would lower down in position. LVN E stated it was on her admission on 11/16/24. LVN E stated Resident #4 was a high risk for falls. LVN E stated that the bed mattress was placed on the floor along with Resident #4 who was laid on top of it, while they switched out the bed. LVN E stated it would not be appropriate placing a fall mat against the resident's bed with furniture pushed up against it. LVN E stated it would be considered a restraint. LVN E stated when they applied it and the way they had used it was used as an intervention to Resident #4 from falling. LVN E stated it was not done on any other residents. During a follow-up interview on 12/12/24 at 11:15 AM, LVN E stated Resident #4 was combative and as per policy they could use the fall mat as an intervention as the least restrictive. LVN E stated Resident #4's bed was placed to the corner next to the wall near the bathroom. LVN E stated the bed rail created a gap between the bed and the wall and thought Resident #4 might have a fall in between the gap. LVN E placed pillows and blankets to keep Resident #4 from falling on the right side of the bed closet to the wall and on the other side a fall mat was placed leaning against Resident #4's bed. LVN E stated Resident #4 was able to yell out and move and LVN M and her did not tie her down. LVN E stated this took around 10 minutes while they got the other bed and conducted the switch of beds for Resident #4. LVN E stated Resident #4 was not along and had LVN M (the Floor Nurse for that hallway)in the room with CNA J working in and out of the room. LVN E stated it was an intervention for Resident #4. During an interview on 12/11/24 at 4:34 PM, LVN M stated residents nor staff have reported to her staff placing fall mats against residents' beds with furniture pushed up against them. LVN M stated that was not appropriate as it was a restraint. LVN M stated Resident #4 during admission was impulsive and wanted to dance. LVN M stated Resident #4 was a high fall risk. LVN M stated Resident #4's bed was not changed out that day. LVN M stated her and LVN E did not place Resident #4 on the floor on top of her mattress. LVN M stated she had no reason to do that, and the facility staff know this. LVN E stated it was a dignity issue. LVN M stated she had not seen a fall mat placed against Resident #4's bed with furniture pushed up against it. LVN M stated she had been trained on Restraints and would consider it a restraint. During an interview on 12/11/24 at 4:28 PM, with CNA J, he stated he worked on 11/16/24 and 11/23/24 on the weekend. CNA J stated he had not seen nor heard from staff or /residents saying staff were placing fall mats against residents' beds with furniture pushed up against it. CNA J stated this would not be right and would be a restraint. CNA J stated he had been trained on Abuse, Neglect, and Exploitation and Restraints. During an observation on 12/10/24 at 8:24 AM, Resident #4 was lying in bed asleep with no fall mat placed on the floor next to the bed. The fall mat was placed over on the dresser of the roommate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 2:19 PM, the DON stated she had not seen fall mats being placed against resident beds and held up by furniture. The DON stated that would be inappropriate and would be considered a restraint. The DON stated when Resident #4 got to the facility she was very anxious, but it would not warrant having the fall mats placed against the bed with furniture propped up against it. During an interview on 12/10/24 at 2:42 PM, the Administrator stated no one had reported to him that a fall mat or nursing tray tables were being placed against the bed of a resident who was on the bed. The Administrator stated if the staff did that, he would think it was to prevent a fall. The Administrator stated he would think there would be better ways like placing the bed in the lowest position instead of placing the fall mat against the bed with furniture push up against the fall mat. The Administrator stated he would consider it a restraint at the minimum. The Administrator stated this was not acceptable practice and not acceptable because the facility has better interventions. During an interview on 12/11/24 at 8:20 AM, Resident #4, stated she did not remember anything. Resident #4 looked downwards and did not say anything else. During an interview on 12/12/24 at 8:35 AM, the DOR stated Resident #4 was weak. The DOR stated Resident #4 for bed mobility was max to moderate assistance to max assistance. The DOR stated if a fall mat was placed against the resident's bed and had furniture up against it then Resident #4 might not be strong enough to move it out of the way. The DOR stated it would be a hazard. During an interview on 12/12/24 at 8:58 AM, NP D stated Resident #4 was a high risk for falls. NP D stated it had not been reported to him that the fall mats were being used to be placed against Resident #4's bed and had furniture pushed up against it. NP D stated the fall mat would be used as an intervention to prevent falls but would have to be laid on the floor next to the resident's bed. NP D stated having the fall mat pushed up against the resident's bed with furniture propped up against it was not allowed to happen. NP D stated he had never seen that before and was a risk as it was obstacle to the resident. NP D stated he was going to talk to the facility MD regarding the allegation as it was concerning. NP D stated Resident #4 might be able to move the objects out of the way. Resident #5 Record review of Resident #5's face sheet dated 12/10/24, reveled, admission on 01/10/24 and re-admission on 11/06/24 to the facility diagnosed with muscle weakness, muscle wasting, lack of coordination, cognitive communication deficit, and repeated falls. Record review of Resident #5's facility history and physical dated 11/06/24, revealed, a [AGE] year-old male diagnosed with Alzheimer Dementia and benign prostatic hypertrophy. Record review of Resident #5's quarterly MDS dated [DATE], revealed, there was no BIMS score taken to measure the recall or daily cognition of the resident. Functional abilities revealed substantial/maximal assistance (Nursing staff does more than half the work) for rolling left or right in bed, sit to lying, lying to sitting on side of bed, sit to stand, chair to bed and bed to chair, and toilet transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's care plan dated 01/10/24, revealed, had swallowing problem and at risk for aspiration, aspiration pneumonia and upper respiratory infections. Maintain HOB elevated to 30-45 degrees angle during feedings. Had impaired thought process related to Alzheimer's Dementia. Provide me with a homelike environment. At risk of falls related to unaware of safety needs. Be sure call light was within reach and encourage me to use it for assistance as needed. Follow facility fall protocol. I need a safe environment free from clutter, a reachable call light. Floor mat beside my bed at all times when I'm in bed. ADLs requires extensive assistance x2 staff to turn and reposition when in bed for bed mobility. Observation of a photo of Resident #5 provided to state agency by unknown person not dated but reviewed on 12/09/24, revealed, Resident #5 was in bed lying on his back with his left hand up. To the right side of Resident #5 was a blue fall mat placed sideways standing up against his bed, while on the left side of the bed was the room wall. Pushed up against the blue fall mat was a chair and a nurse's tray table. During an observation and interview on 12/10/24 at 2:00 PM, with Resident #5 and CNA B. Resident #5 was in his bed awake. Resident #5 did not have a fall mat placed next to his bed. When Resident #5 was asked questions, he would just look and move his hands. CNA B stated when Resident #5 was in bed that the fall mat should be placed in case, he had a fall to prevent an injury. CNA B stated it was the responsibility of the CNAs to ensure the fall mat was placed. During an interview on 12/10/24 at 2:19 PM, the DON stated the fall mat against Resident #5's bed pushed against by furniture was inappropriate. The DON stated she considered it a restraint. The DON stated Resident #5 was a high fall risk and his mat should be placed on the floor next to his bed. The DON stated staff understood they should not be doing that. During a follow-up interview on 12/12/24 at 11:15 AM, LVN E stated she would not know why anyone would place a fall mat against Resident #5's bed with furniture pushed against it. During a follow up interview on 12/12/24 at 8:35 AM, the DOR stated Resident #5 had been on case load for therapy. The DOR stated Resident #5 was total dependence (nursing staff assist with total assistance) for ADLs . The DOR stated Resident #5 was fidgety (constantly making small, restless movements with your body). The DOR stated if a fall mat was placed against the resident's bed and had furniture up against it then Resident #5 would not be able to move it out of the way because he was not strong enough to be able too. DOR stated it would be a hazard. During an interview on 12/12/24 at 8:58 AM NP D stated Resident #5 was very confused but managed to get out of bed by himself. NP D stated Resident #5 had never been verbal with him. NP D stated if the fall mat was placed against the Resident #5's bed with propped furniture against it then Resident #5 would not have the strength to move the objects out of the way. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Provider Investigation Report dated 11/25/24, for Resident #4 and Resident #5, revealed, Incident Date: 11/16/24. Description of allegation: On 11/16/24, Resident #4 was admitted to the facility for long term care. Resident #5 has been admitted to the facility since around 2022. On 11/16/24, in the evening, LVN E, restrained resident #4 and Resident #5 in their beds with fall mats held against the bed by furniture. The residents had a rolled-up blanket placed under their fitted sheet to further restrain them. This was reported to the Administrator. LVN E stated this was her solution to prevent providing one to one supervision to the resident who have been Fidgety (jittery, restless, or anxious). On 11/23/24, the residents were restrained in their beds again. Record review of LVN E's Timesheet dated 11/16/24, revealed, LVN E working from 6AM-9:08 PM. On 11/23/24- worked 2:01PM-10:05PM. LVN E was not on any floor schedule as she was the Weekend Supervisor. Record review of LVN M's Timesheet dated 11/16/24, revealed, LVN M working from 6:12 AM-10:50PM. Record review of LVN M's floor schedule dated 11/16/24, revealed, working 100 hall from 6AM to 10PM. On 11/23/24 - worked 100 hall from 6AM to 10PM. Record review of CNA J's Time sheet dated 11/23/24, revealed, CNA J working from 6:06AM-10:08PM. On 11/23/24 - worked 6:09AM-2:03PM. Record review of CNA J's floor schedule 11/16/24, revealed, working 100 hall from 6AM to 10PM. On 11/23/24- worked 100 hall from 10:15AM-2PM. Record review of CNA K's Timesheet dated 11/16/24, revealed, CNA K working from 6:17AM-10:08PM. On 11/23/24- worked 6:18PM-10:09 PM. Record review of CNA K's floor schedule dated 11/16/24, revealed, working 100 hall from 10:30AM - 7:30 PM. On 11/23/24- worked 100 hall from 10AM to 7PM. Record review of the facility Incidents and Accidents policy noted dated, revealed, Policy: It was the policy of this facility for staff to utilize) specify risk management system/tools used) to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident. Accident - refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. Incident was defined as an occurrence or situation that was not consistent with the routine care of a resident or with the routine operation of the organization. If an incident/accident was witnessed by other people, the supervisor or designee will obtain written documentation of the event by those that witnessed it and submit that documentation to the Director of Nursing and or Administrator. Record review of the facility Fall Prevention Program policy not dated, revealed, Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individual level of risk to minimize the likelihood of falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Provide additional interventions as directed by the resident's assessment, including but not limited to: Assistive devices.