STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455941	A. Building B. Wing	06/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enchanted Rock Skilled Nursing and Rehabilitation	210 West Windcrest St Fredericksburg, TX 78624

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as is possible; and each resident received assistance devices to prevent accidents for 1 of 3 Residents (Resident #1) whose records were reviewed for falls. Nursing staff failed to ensure both brakes on Resident #1's wheelchair were locked while not in use and that Resident #1's call light was in place per Resident #1's Care Plan. These deficient practices could affect any resident at risk for falls and could contribute to a decline in resident's physical health. The findings were: Review of Resident #1's face sheet, undated, revealed she was admitted to the facility on [DATE] with diagnoses including unspecified Dementia, unspecified abnormalities of gait and mobility, unspecified lack of coordination and cognitive communication deficit. Review of Resident #1's MDS assessment, dated 6/12/24, revealed her BIMS was 5 of 15 reflecting severe cognitive impairment; she required extensive to total assistance with ADLs from 1 to 2 staff, and she had experienced multiple falls. Review of the incident accident log revealed Resident #1 had experienced multiple falls since December 2023 including: 12/8/23: Resident #1 attempted unassisted transfer from wheelchair to bed; upon assessment no injury was noted. 3/2/24 Resident #1 fell from wheelchair leaning over to pick up something; laceration to forehead and swelling to nose. 3/25/24 Nurse observed Resident #1 sitting upright leaning against the bed, call light within reach, side table present not in the way. No apparent injuries noted. Resident stated she slid out of bed, denied self-transferring. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/7/24 CNA made nurse aware that Resident #1 was noted to be face down on floor near doorway with blood noted to her head; laceration to head. Resident #1 stated I was putting on my shoes and I fell out of bed and hit my head on the doorway. 5/10/24: Resident #1 stood up from wheelchair and fell ; no injury noted. Resident #1 stated she lost her balance. 5/13/24: Resident #1 lying on floor with head resting near the food of the bed. Upon assessment noted raised, reddened area to right side of forehead. Resident #1 stated I remember getting up and I remember falling down. Applied ice to knees. 6/8/24: Nurse was assisting another resident across the hallway and heard Resident #1 hollering for help. She called for help. Staff responded and saw the Resident on the floor on her knees and bending over her bed which was in the lowest position. Resident #1 stated she wanted to walk in the hall; no apparent injuries. 6/9/24: Resident #1 was lying face beside her bed. Resident #1 stated reaching for shoes on the wheelchair and fell off the bed. Upon assessment, Resident #1 noted with redness to left side, rib area, laceration to right eyebrow, right posterior forearm. Neck was stabilized as she was log rolled onto her back. No internal/external rotation. No length difference. 2 steri-strips applied to right eye brow and 1 steri-strip applied to right hip. 6/10/24: Resident #1 noted laying on the floor, head by the foot of the bed; in room. Resident #1 stated she fell from wheelchair tried to get up without assistance. Her right eye remained swollen and purple in color with steri strips in place from previous fall. Left arm steri strips from previous fall in place. 6/19/24: CNA's alerted nurse that Resident #1 was noted to be face down on the floor near the bed. Resident #1 stated I was trying to roll out of ed to get up but I fell face first on the floor. Noted bruising and slight swelling to eyes. Review of Resident #1's Acute Care Plan revised on 6/19/24, read: Actual fall: 6/19/24, tried to get out of bed and rolled out on to floor, bruising and swelling to eyes. 6/10/24: on floor in room fell from wheelchair tried to get up without/ assist right eye swollen. 6/9/24: face down on floor in room stated reaching for shoes and fell off bed, laceration to right posterior arm and red raised area to right hip. 6/8/24: on floor in room on her knees; stated she wanted to walk in the hall no injury. 5/13/24: lying on floor next to bed stated she recalls getting up out of bed and falling. 5/10/24: stood from wheelchair fell no injury stated she lost her balance no injury. 5/7/24 on floor in door entry with laceration to head. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/2/24 fell from wheelchair leaning over to pick up something. laceration to forehead and swelling to nose. 12/8/23: she attempted unassisted transfer from wheelchair to bed no injury. Further review of Care Plan revealed interventions which included: 6/19/24 neuron- checks. 6/11/24 Discussed with resident her injury related to/ poor safety awareness, educated related to using her call light, she discussed wanting to use her walker freely, continues to have a strong since of independence, admitted doesn't do what is supposed to do. reiterated staff is here to assist as she needs; ensure bed is in lowest position, frequent reminders to use call light and wait for assistance with ADLS. Discussed with resident her increase number of falls recently states she knows but doesn't know why I keep falling, discussed using call light and allowing staff to provide her stand by assistance so she can still be independent but we are there for support wen needed such as steadying her gait and helping her ambulated safely. 6/10/24 placed non-skid socks on resident, reeducated resident on using call light and waiting for staff to come and assist her to bed. 6/3/24 discussed resident that if items fall on floor then please use call light to alert staff to retrieve items for her. 5/12/24 increase room round frequencies. before leaving room. 5/10/24 encourage to call for assist for transfers, offer to assist to bed or recliner. 5/7/24 to ER for laceration repair, neuro - checks, increase rounding. Review of the facility action plan for Resident #1, dated 5/1/24, identified staff was not completing incident reports correctly/completely, not reporting every fall to the DON. Implemented new/reinforced measures: frequent rounding, anticipate resident needs, administrative staff to discuss res falls during morning meetings and during weekly meetings to ensure interventions were in place, falls discussed during Care Plan meetings. Review of in-service for fall management, dated 6/19/24, after Resident #1's last fall revealed 9 staff attended the in-service. Observation and interview on 6/20/24 at 12:05 PM, in the main dining room during lunch meal, revealed Resident #1 sitting at one of the tables. She had black, purple and yellow bruising around her right eye. Resident #1 stated she fell a couple of nights ago. Further interview stated she felt ok today. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 6/20/24 at 3:00 PM with Resident #1 revealed she was lying in bed; bed in low position with call light clipped to the top of the cover. The wheelchair was positioned at the foot of the bed; right side was locked but left side was not locked. Wheelchair moved to the right when pushed on it. Resident #1 noted with bruising around right eye and fading light green discoloration to the top of her forehead with a scar about 3 cm long. Interview with Resident #1 revealed she stated the scar on her forehead, probably got it from a fall. She stated fell yesterday and other times. Resident #1 was able to explain the function of the call light. She stated staff would respond when she triggered the call light but it would take time. Resident #1 was unable to elaborate. She presented as being alert but with very slow thought process. Interview on 6/21/24 at 11:20 AM with CNA A revealed Resident #1 had a fall a couple of days ago. She stated she normally worked another hall but would often pick up shifts and worked whatever hall they needed her to work. CNA A stated she was working with Resident #1 on this date. She stated Resident #1 required total care but would not ask for assistance. She stated some of the interventions included low bed, call light within reach and staff had to do frequent rounds on Resident #1 Observation and interview on 6/21/24 at 6:30 PM revealed Resident #1 was lying in bed; it was in the low position; call light was on the floor on Resident #1's left had side and the wheelchair at the foot of the bed was not locked. Interview with Resident #1 did not respond when asked about the call light placement or if she used the wheelchair. Observation and interview on 6/21/24 at 6:37 PM with MA B revealed was aware Resident #1 was a fall risk and she had a fall most recently. MA B stated Resident #1's bed should remain in the lowest position, call light within reach, wheelchair should be locked at all times and kept at the foot of the bed and the path to the doorway and bathroom should be free of any obstacles/safety hazards. Observation upon entering Resident #1's room revealed she was lying in bed, bed in low position. Her call light was on the floor and the wheelchair at the end of the bed was not locked. MA B stated Resident #1 new how to use the call light, did not always use it but should be within reach. She stated the wheelchair should be locked because Resident #1 was impulsive, had a tendency to get out of bed and if she tried to transfer into the wheelchair it would roll and Resident #1 would fall. MA B stated Resident #1 could not stand up on her own and had unsteady gait. Observation and interview on 6/21/24 at 7:16 PM with CNA D revealed she put Resident #1 to bed after dinner between 6:00 PM to 6:05 PM. Put bed in lowest position. She stated the DON asked to shower a resident on 300 hall. She stated she forgot to put Resident #1's call light back in place. She remembered putting the wheelchair at the end of the bed because if had left it the bed Resident #1 would try to use it. She stated Resident #1 would try to stand up. CNA D stated she did not remember locking the wheelchair but stated she should lock it because it could be a safety hazard for Resident #1. Interview on 6/21/24 at 7:40 PM with the DON revealed Resident #1 was a high fall risk because she would try to stand up and walk on her own bur was unable to because she had poor balance and unsteady gait. The DON stated Resident #1 had fallen multiple times. She stated Resident #1 did not always use the call light, was determined to maintain her independence and would not ask for assistance for transfers. The DON stated in an effort to keep Resident #1 as safe as possible nursing staff was to anticipate her needs, check in on her frequently, keep her bed in the lowest position, keep the call light within reach, keep the wheelchair at the foot of the bed and in the locked position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy, Fall Prevention Program, dated 6/22, read: Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. Policy Explanation and Compliance Guidelines: 1. The facility utilizes a standardized risk assessment for determining a resident's fall risk. a. The risk assessment categorizes residents according to low, moderate, or high risk. b. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 3. The nurse will indicate on the care plan and POC for nursing assistants, the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. 4. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. 6. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan. ii. Place Fall Prevention Indicator (yellow color-coded sticker) on the name plate to resident's room. iii. Place Fall Prevention Indicator on resident's wheelchair. b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: i. Assistive devices ii. Increased frequency of rounds (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. Sitter, if indicated iv. Medication regimen review v. Low bed vi. Alternate call system access vii. Scheduled ambulation or toileting assistance viii. Family/caregiver or resident education ix. Therapy services referral