STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway New Braunfels, TX 78130

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, for 1 of 4 residents (Resident #1) reviewed for neglect. The facility failed to report an incident to the State Survey Agency (HHSC) immediately but not later than 24 hours, when Resident #1 fell face first from a wheelchair hitting her head and face on the ground which required emergency evaluation at a hospital. This failure could place the residents at risk for unreported allegations of abuse, neglect, and injuries of unknown origin. The findings were: Record review of Resident #1's face sheet dated 06/08/2022 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke). Generalized muscle weakness, vascular dementia without behavioral disturbance (a condition caused by lack of blood that carries oxygen to parts of the brain resulting in problems with reasoning, planning, judgment, and memory), repeated falls, and paroxysmal atrial fibrillation (a heart condition with irregular heartbeat). Record review of Resident #1's Care Plan dated 4/24/2021 revealed the resident was at risk for falls related to impaired cognition and a history of repeated falls, impaired vision and hearing .with interventions which included: assess reason for fall, staff education on proper positioning in the chair. Record review of Resident #1's quarterly assessment dated [DATE] revealed a BIMs of 5 (scale of 0-15) which indicated a severe cognitive impairment. Record review of Resident #1's quarterly assessment dated [DATE] revealed Resident #1 was unable to ambulate (walk) and required extensive assistance of staff to transfer, change position and move around the facility in a wheelchair. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nursing progress notes dated 06/06/2022 at 6:00 p.m. revealed: Reported by NA A, resident was sitting in wheelchair being pushed into bedroom by NA A. Residents feet were not lifted off the ground and got stuck under the chair: as stated by NA. Resident hit her forehead on the ground. No pain or discomfort noted, vital signs stable, resident does have carpet burn noted to forehead with increased swelling. Ice placed on resident's forehead. Notified NP, RP, and DON .orders to send out resident for a CT. Resident sent out of the building at 6:45 p.m.Documented by RN B. Record review of an accident/incident report dated 6/06/2022 revealed Resident #1 had a witnessed fall from chair on 6/06/2022 at 6:00 p.m. when Resident #1 was sitting in wheelchair pushed into bedroom by NA A. Resident #1's feet were not lifted off the ground and got stuck under the chair. Resident #1 hit her forehead on the ground .carpet burn noted to forehead with increased swelling. Resident #1 was sent to a local hospital emergency room for evaluation and treatment at 6:45 p.m. The primary injury was listed as contusions/hematoma, head involved. The DON was notified of the incident on 6/06/2022 at 6:20 p.m. by RN B. Record review of Resident #'1 hospital record dated 6/06/2022 revealed the results of a CT scan of the head and cervical spine which indicated the resident had small left para midline (left of midline or left side of forehead) frontal scalp edema and hematoma (swelling and bruising or collection of blood outside of the blood vessels typically caused by trauma) without fracture (break in bone) or intracranial change (changes inside the brain). During an interview on 6/08/2022 at 3:43 p.m. LVN C stated on the morning on 6/07/2022 she received in report (unknown staff) that Resident #1 was being pushed in a wheelchair on 6/06/2022 during the evening shift when she fell forward. LVN C stated she did not know who was pushing Resident #1 in the wheelchair when the fall occurred. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/08/2022 at 4:16 p.m. NA A stated on 6/06/2022 at approximately 6:00 p.m. Resident #1 was self-propelling (using her feet to move herself in the wheelchair) down the hallway toward her room. NA A stated Resident #1 was not very far from her bedroom, approximately 2-3 doorway. NA A stated she needed to change Resident #1's brief, so she decided to push the resident the remainder of the way in the wheelchair. NA A stated she told Resident #1 let's go change you and began pushing the wheelchair forward. NA A stated she did not wait for the resident to respond to her because the resident did not normally respond. NA A stated Resident #1 was sitting forward on the seat of the wheelchair and was not sitting with her back against the backrest. NA A stated Resident #1's buttock and back were approximately 3 finger widths away from the back of the wheelchair. NA A stated, I should have pulled her back in the chair, but I didn't and when we turned the corner her feet got stuck underneath the wheelchair. NA A stated Resident #1 fell forward. She stated her feet went under the seat and she fell forward. NA A stated she tried to grab Resident #1's shirt, but it happened so quick. NA A stated Resident #1 fell forward and hit her forehead on the carpeted floor. NA A stated it happened so quick that Resident #1 was not able to put her arms out to stop or break the fall. NA A stated while pushing Resident #1 she noticed the resident was unable to hold her feet up while the wheelchair was moving. She stated Resident #1's feet kept going up and down. NA A stated she did not use footrests because Resident #1 does not have footrests on the wheelchair because she normally self-propels, and she needs them off the chair to be mobile. NA A stated, I should have pulled her back in her seat and this would not have happened, I know better than that. I go above and beyond for all my patients it was an accident and it happened so quick. NA A stated after Resident #1 fell she notified the ADON, identified as LVN E who assessed the resident. NA A stated Resident #1 stated she was okay even when the ambulance took her out of the facility. NA A stated no one from management had asked her to write a witness statement. NA A stated on 6/07/2022 the DON asked her what had happened. NA A stated she told the DON the same thing she told stated in this interview. NA A stated after speaking to the DON she was sent home. She stated she completed new orientation competencies and training and had participated in lots of in-service trainings but could not remember what the trainings covered. She stated had participated in a resident movement training that address patient positioning, but she had not had any training specifically addressing pushing wheelchairs or wheelchair safety. NA A stated she had not been asked to complete or participate in any trainings since Resident #1's fall incident. During an interview on 6/08/2022 at 4:55 p.m. LVN E stated she was the facility's Infection Preventionist and a member of the facility management team and a former ADON (as of January 2022) for the facility. LVN E stated on 6/06/2022 she was sitting in her office at approximately 6:00 p.m. LVN E stated Resident #1 peaked into her office to talk. LVN E stated Resident #1 who had dementia would often say hi and then move along the hallway by self-propelling in her wheelchair. LVN E stated she heard NA A ask if she wanted or needed to go to the bathroom and heard Resident #1 respond, yes. LVN E stated she looked up and saw the back of NA A pushing Resident #1 in the wheelchair towards her room. LVN E stated quickly after observing, NA A came and got her and stated Resident #1 had a fall. LVN E stated when she arrived at the resident, she was lying on the floor on her left side just inside the doorway to her room. LVN E stated she asked NA A Weren't you with her? LVN E stated NA A stated, Yes, but I could not catch her. LVN E stated she asked NA A what happened and NA A stated Resident #1 put her feet down while she was pushing her in the wheelchair. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/08/2022 at 5:25 p.m. RN B stated on 6/06/2022 at an unknown time near change of shift, she was notified by LVN E that Resident #1 had fallen. RN B stated Resident #1 was still on the floor when she arrived. She stated Resident #1 denied pain but had carpet burn and swelling to her forehead when EMS arrived at the facility. RN B stated she did not witness the incident, but asked NA A what happened. RN B stated, NA A said she was wheeling the resident to her room when Resident #1 fell forward headfirst and hit her head on the floor, immediately inside the resident room. RN B stated she notified ADON G and the DON of the incident on 6/06/2022 (unknown time). During an observation/interview on 6/09/2022 at 8:30 a.m., Resident #1 was observed in a hospital bed at hospital in an adjacent city. Resident #1 had her eyes closed and did not open her eyes or respond to voice. Resident #1 was observed with a large bruise and swelling to her forehead, midline and to the left, with several small, scabbed areas and one large approximately 4 cm x 2 cm abrasion/open area to her forehead. Resident #1 also had bruising and swelling to both eyes and a small amount of bruising to her left cheekbone. During an interview on 6/09/2022 at 8:44 a.m. with a RN at the hospital revealed Resident #1 had dementia and was unable to answer interview questions due to dementia and antipsychotic medication. The RN stated Resident #1 had repeat CT scans on 6/08/2022 of her head which showed no abnormalities related to the fall incident. The RN stated the resident was being treated for a urinary tract infection and metabolic encephalopathy (a condition in which brain function is disturbed due to abnormalities of water, electrolytes, vitamins, or other chemicals that adversely affect brain function). During an interview on 6/09/2022 at 11:40 a.m. the DON stated she was notified of Resident #1's fall incident by an unknown staff member on an unknown date and time. The DON stated she was informed Resident #1 hit her head and the staff was sending her out because she was on blood thinners to make sure she didn't have a brain bleed. The DON stated on 6/08/2022 a state surveyor was in the facility which changed her day. The DON stated on 6/09/2022 she looked through fall reports again and asked NA A to come give a statement. The DON stated after speaking with NA A she gave the aide a training on positioning and transferring and she suspended NA A because she had not finished her investigation. The DON stated she needed to finish her investigation before commenting further. The DON stated she had not reviewed Resident #1's medical records at the time of this interview. During an interview on 6/09/2022 at 2:23 p.m., the DON stated in light of further investigation and learning new information as of 6/09/2022 the facility would be reporting Resident #1's fall incident to the State Survey Agency (HHSC). The DON stated the facility policy stated she had 72 hours to review a fall incident, come to a conclusion that something wasn't right, discuss with the Administrator and her boss and the Administrators boss, tell them what was found and make a decision on reporting based on the findings. The DON stated HHSC reporting guidelines stated the facility had two hours to report this fall incident with Resident #1. The DON stated she just discovered a change and reported as soon as she discovered the change. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/09/2022 at 5: 23 p.m. RN B stated when she notified the DON, she did not have the information about Resident #1's feet getting stuck under the wheelchair, so she did not tell the DON that information. She stated she did not notify the DON after she learned this information because she documented it in Resident #1 nursing progress notes. RN B stated she put the details in the note for a reason and that reason was because the DON does an assessment after a fall occurs. RN B stated the DON would review the information and close the incident. RN B stated the DON typically reviewed a fall incident and closed it within 24 hours of occurrence. RN B stated as of the date and time of this interview neither the DON or the Administrator or any member of the management team had asked her what occurred during or after the incident and she had not been asked to write a witness statement. During an interview on 6/09/2022 at 4:16 p.m. ADON G stated she was the Assistant Director of Nurses for the side of the building in which Resident #1 resided. She stated her job duties included overseeing everything on that side of the building and reporting any abuse/neglect concerns for allegations directly to the Administrator and DON. ADON G stated she was on a break on 6/06/2022 at approximately 7:00 p.m. when RN B came and told her Resident #1 fell . ADON G stated RN B said NA A was pushing the resident when her feet got caught under the wheelchair causing her to fall and hit her head. She stated Resident #1 had a hematoma (swelling and bruising) to her forehead and was sent to a local ER but came back to the facility the same night at approximately 10:00 p.m. ADON G stated she did not provide any oversite to the fall incident, did not review Resident #1's nurses notes or medical record the next day. She stated she did go to morning meeting the next day on 6/07/2022, but the incident was not discussed because the RP arrived at the facility and the Administrator and DON left the meeting to talk to her. ADON G stated neither the Administrator nor the DON came back to the meeting, so another staff member dismissed the meeting. ADON G stated as of the date and time of this interview she had not reviewed Resident #1's nursing notes, change of condition forms or anything related to the fall incident. She stated, I have not even looked at her chart. ADON G stated she did not review the incident because she was stuck on the floor training new staff. She stated since she was new to the ADON position she did not know what her job responsibilities entailed. ADON G stated she didn't know what her responsibility was and what she should leave for the DON. ADON G stated she did discuss with LVN E, NA A's comment I guess I could have pulled her back in the wheelchair first on the day of the incident (6/06/2022). She stated she did not report the comment to the DON or the Administrator because it was hearsay. ADON G stated she did not have any concerns that needed to be reported because she had worked with NA A for a while and had never seen her do anything to harm a resident. ADON G stated no one from the management team had asked her what had occurred on 6/06/2022 and she had not been asked to write a witness statement. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/10/2022 at 12:45 p.m., the Administrator stated all fall incidents were discussed during meetings the next day. He stated the DON was responsible for reviewing fall incidents and accidents. The Administrator stated the DON had the ability to pull records, to look at lists and sometimes staff will notify her of the incident. The Administrator stated he was not notified of Resident #1's fall incident on 6/06/2022. He stated the first he heard of it was the following day, 6/07/2022. He stated he was notified that Resident #1 had a fall. He stated he asked if she had an injury, and someone (unknown staff) stated she hit her head on carpet when she fell forward and was to the ER because she was on blood thinners to rule out a brain bleed. He stated this occurred during morning meeting, which was interrupted because Resident #1's RP arrived at the facility. The Administrator stated Resident #1's fall incident was discussed during the meeting. The Administrator stated the DON looks at fall incidents every day. The Administrator stated a few days later the DON will ask him to lock the incident document. The Administrator stated the DON did her part on 6/09/2022 and the document was reviewed and locked today (6/10/2022). The Administrator stated he was not able to answer the question about time frame for reviewing and locking the documents because he would need to review the facility policy. The Administrator stated this incident took longer than typical to review because NA A was off the schedule and a surveyor was in the facility. The Administrator stated NA A stated she wished she would have done things differently, The Administrator stated he was not saying it was neglect, but it suggested we failed to do something which caused an injury. The Administrator stated normally the DON would start the investigation right away, but the facility thought it was just a freak accident. The Administrator stated he was the facility's Abuse Coordinator. He stated he provided in-services on abuse/neglect to staff and encouraged staff to report things so he could assess the situation. The Administrator stated on 6/09/2022 after speaking with NA A, the facility discovered new information and the fall incident was reported after the new information was discovered. The Administrator stated an incident of neglect should be reported within a couple of hours of occurrence. Record review of a facility policy, titled Accidents/Incidents dated May 2016 revealed 1. An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident involving a Patient .Each Accident/Incident Report for an accident/incident occurring during a month must be signed by the Executive Director and Director of Nursing within 48 hours of the occurrence. 2. A witness statement must be completed at the time of the accident/incident. 14. The Executive Director serves as the Abuse Prevention Coordinator. In the absence of the Executive Director, the Director of Nursing or designee will fulfill the duties of the Abuse Prevention Coordinator. When an allegation of abuse or actual abuse is identified, the abuse protocol must be implemented. 17. Accidents/Incidents must be reported both internally and externally in accordance with the Reportable Incident Protocol. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy, titled Reportable Incident Protocol dated November 2017 revealed: 1. Ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property, are reported immediately, but no later than 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury, to the Executive Director of the facility to other officials (Including State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. Upon the occurrence of an accident/incident that the facility staff has reason to believe meets the criteria for being reportable, staff must immediately contact the Execute Director or the Director of Nursing. The Executive Director or Director of Nursing must immediately contact DADS [State Survey Agency]. Record review of a facility policy, titled Abuse Protocol dated April 2019 revealed: The Abuse Prevention Coordinator will a. Immediately (within 2 hours) report to The Department of Aging and Disability Services (DADS) [State Survey Agency/HHSC] and other appropriate authorities' incidents of patient abuse as required under applicable regulations and regulatory guidance. Report events that cause reasonable suspicion of serious bodily injury immediately (within 2 hours) after forming the suspicion to The Department of Aging and Disability services (DADS) and other appropriate authorities as required under applicable regulations and regulatory guidance.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure that all alleged violations of abuse, neglect, exploitation, or misappropriation of property were thoroughly investigated in order to prevent further potential abuse, neglect, exploitation or misappropriation while the investigation was in progress for 1 of 4 residents (Resident #1) reviewed for abuse and neglect, in that: The facility failed to immediately and thoroughly investigate an incident when Resident #1 fell face first from the wheelchair hitting her head and face on the ground which required emergency evaluation at a hospital. This failure could place residents at risk for not having allegations of neglect investigated in a timely manner. The findings were: Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke). Generalized muscle weakness, vascular dementia without behavioral disturbance (a condition caused by lack of blood that carries oxygen to parts of the brain resulting in problems with reasoning, planning, judgment, and memory), repeated falls, and paroxysmal atrial fibrillation (a heart condition with irregular heartbeat). Record review of Resident #1's Care Plan dated [DATE] revealed the resident was at risk for falls related to impaired cognition and a history of repeated falls, impaired vision and hearing .with interventions which included: assess reason for fall, staff education on proper positioning in the chair. Record review of Resident #1's quarterly assessment dated [DATE] revealed a BIMs of 5 (scale of , d+[DATE]) which indicated a severe cognitive impairment. Record review of Resident #1's quarterly assessment dated [DATE] revealed Resident #1 was unable to ambulate (walk) and required extensive assistance of staff to transfer, change position and move around the facility in a wheelchair. Record review of Resident #1's nursing progress notes dated [DATE] at 6:00 p.m. revealed: Reported by NA A, resident was sitting in wheelchair being pushed into bedroom by NA A. Residents feet were not lifted off the ground and got stuck under the chair: as stated by NA. Resident hit her forehead on the ground. No pain or discomfort noted, vital signs stable, resident does have carpet burn noted to forehead with increased swelling. Ice placed on resident's forehead. Notified NP, RP, and DON .orders to send out resident for a CT. Resident sent out of the building at 6:45 p.m.Documented by RN B. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an accident/incident report dated [DATE] revealed Resident #1 had a witnessed fall from chair on [DATE] at 6:00 p.m. when Resident #1 was sitting in wheelchair pushed into bedroom by NA A. Resident #1's feet were not lifted off the ground and got stuck under the chair. Resident #1 hit her forehead on the ground .carpet burn noted to forehead with increased swelling. Resident #1 was sent to a local hospital emergency room for evaluation and treatment at 6:45 p.m. The primary injury was listed as contusions/hematoma, head involved. The DON was notified of the incident on [DATE] at 6:20 p.m. by RN B. Record review of Resident #'1 hospital record dated [DATE] revealed the results of a CT scan of the head and cervical spine which indicated the resident had small left para midline (left of midline or left side of forehead) frontal scalp edema and hematoma (swelling and bruising or collection of blood outside of the blood vessels typically caused by trauma) without fracture (break in bone) or intracranial change (changes inside the brain). During an interview on [DATE] at 3:43 p.m. LVN C stated on the morning on [DATE] she received in report (unknown staff) that Resident #1 was being pushed in a wheelchair on [DATE] during the evening shift when she fell forward. LVN C stated she did not know who was pushing Resident #1 in the wheelchair when the fall occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:16 p.m. NA A stated on [DATE] at approximately 6:00 p.m. Resident #1 was self-propelling (using her feet to move herself in the wheelchair) down the hallway toward her room. NA A stated Resident #1 was not very far from her bedroom, approximately ,d+[DATE] doorway. NA A stated she needed to change Resident #1's brief, so she decided to push the resident the remainder of the way in the wheelchair. NA A stated she told Resident #1 let's go change you and began pushing the wheelchair forward. NA A stated she did not wait for the resident to respond to her because the resident did not normally respond. NA A stated Resident #1 was sitting forward on the seat of the wheelchair and was not sitting with her back against the backrest. NA A stated Resident #1's buttock and back were approximately 3 finger widths away from the back of the wheelchair. NA A stated, I should have pulled her back in the chair, but I didn't and when we turned the corner her feet got stuck underneath the wheelchair. NA A stated Resident #1 fell forward. She stated her feet went under the seat and she fell forward. NA A stated she tried to grab Resident #1's shirt, but it happened so quick. NA A stated Resident #1 fell forward and hit her forehead on the carpeted floor. NA A stated it happened so quick that Resident #1 was not able to put her arms out to stop or break the fall. NA A stated while pushing Resident #1 she noticed the resident was unable to hold her feet up while the wheelchair was moving. She stated Resident #1's feet kept going up and down. NA A stated she did not use footrests because Resident #1 does not have footrests on the wheelchair because she normally self-propels, and she needs them off the chair to be mobile. NA A stated, I should have pulled her back in her seat and this would not have happened, I know better than that. I go above and beyond for all my patients it was an accident and it happened so quick. NA A stated after Resident #1 fell she notified the ADON, identified as LVN E who assessed the resident. NA A stated Resident #1 stated she was okay even when the ambulance took her out of the facility. NA A stated no one from management had asked her to write a witness statement. NA A stated on [DATE] the DON asked her what had happened. NA A stated she told the DON the same thing she told stated in this interview. NA A stated after speaking to the DON she was sent home. She stated she completed new orientation competencies and training and had participated in lots of in-service trainings but could not remember what the trainings covered. She stated had participated in a resident movement training that address patient positioning, but she had not had any training specifically addressing pushing wheelchairs or wheelchair safety. NA A stated she had not been asked to complete or participate in any trainings since Resident #1's fall incident. During an interview on [DATE] at 4:55 p.m. LVN E stated she was the facilities Infection Preventionist and a member of the facility management team and a former ADON (as of [DATE]) for the facility. LVN E stated on [DATE] she was sitting in her office at approximately 6:00 p.m. LVN E stated Resident #1 peaked into her office to talk. LVN E stated Resident #1 who had dementia would often say hi and them move along the hallway by self-propelling in her wheelchair. LVN E stated she heard NA A if she wanted or needed to go to the bathroom and heard Resident #1 respond, yes. LVN E stated she looked up and saw the back of NA A pushing Resident #1 in the wheelchair towards her room. LVN E stated quickly after observing, NA A came and got her and stated Resident #1 had a fall. LVN E stated when she arrived at the resident, she was lying on the floor on her left side just inside the doorway to her room. LVN E stated she asked NA A Weren't you with her? LVN E stated NA A stated, Yes, but I could not catch her. LVN E stated she asked NA A what happened and NA A stated Resident #1 put her feet down while she was pushing her in the wheelchair. (continued on next page)

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	676472	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway New Braunfels, TX 78130

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 5:25 p.m. RN B stated on [DATE] at an unknown time near change of shift, she was notified by LVN E that Resident #1 had fallen. RN B stated Resident #1 was still on the floor when she arrived. She stated Resident #1 denied pain but had carpet burn and swelling to her forehead when EMS arrived at the facility. RN B stated she did not witness the incident, but asked NA A what happened. RN B stated, NA A said she was wheeling the resident to her room when Resident #1 fell forward headfirst and hit her head on the floor, immediately inside the resident room. RN B stated she notified ADON G and the DON of the incident on [DATE] (unknown time). During an observation/interview on [DATE] at 8:30 a.m., Resident #1 was observed in a hospital bed at hospital in an adjacent city. Resident #1 had her eyes closed and did not open her eyes or respond to voice. Resident #1 was observed with a large bruise and swelling to her forehead, midline and to the left, with several small, scabbed areas and one large approximately 4 cm x 2 cm abrasion/open area to her forehead. Resident #1 also had bruising and swelling to both eyes and a small amount of bruising to her left cheekbone. During an interview on [DATE] at 8:44 a.m. with a RN at the hospital revealed Resident #1 had dementia and was unable to answer interview questions due to dementia and antipsychotic medication. The RN stated Resident #1 had repeat CT scans on [DATE] of her head which showed no abnormalities related to the fall incident. The RN stated the resident was being treated for a urinary tract infection and metabolic encephalopathy (a condition in which brain function is disturbed due to abnormalities of water, electrolytes, vitamins, or other chemicals that adversely affect brain function). During an interview on [DATE] at 11:40 a.m. the DON stated she was notified of Resident #1's fall incident by an unknown staff member on an unknown date and time. The DON stated she was informed Resident #1 hit her head and the staff was sending her out because she was on blood thinners to make sure she didn't have a brain bleed. The DON stated on [DATE] Resident #1's RP came to the facility and was upset. The DON stated, the Administrator and herself spoke with the RP. The DON stated the RP was crying and extremely distraught because she had another elderly relative who had died , she herself had not been feeling well and now her family member had fallen. The DON stated the RP kept saying She is all that I have left in this world. The DON stated they went over the CT scan results which were negative, but the RP still wanted Resident #1 transported to a hospital in an adjacent city for a second opinion. The DON stated the RP wanted to know what happened to her family member. The DON stated she informed the RP that as far as she knew it was a fall. She said she told the RP she would look into it and get back in contact with her. The DON stated she had other issues at the facility on [DATE] to address. On [DATE] a state surveyor was in the facility which changed her day. The DON stated on [DATE] she looked through fall reports again and asked NA A to come give a statement. The DON stated after speaking with NA A she gave the aide a training on positioning and transferring and she suspended NA A because she had not finished her investigation. The DON stated she needed to finish her investigation before commenting further. The DON stated she had not reviewed Resident #1's medical records at the time of this interview. During an interview on [DATE] at 2:23 p.m., the DON stated the facility policy stated she had 72 hours to review a fall incident, come to a conclusion that something wasn't right, discuss with the Administrator and her boss and the Administrators boss, tell them what was found and make a decision on reporting based on the findings. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 5:50 p.m., the DON stated she began the investigation of Resident #1's fall incident on [DATE] by talking to the RP, following up on CT scan results and getting the resident settled at the hospital. The DON stated there were multiple of things that happened at the facility that required her attention that were unrelated to this incident. She stated she did not do anything else to investigate the incident on [DATE]. The DON stated on [DATE] she reviewed the incident report for the fall in the computer system and made sure there were interventions of Resident #1's care plan. She stated those interventions included neuro checks, therapy screening, CT scan, monitor for latent bruising and send to the ER. The DON stated she was not there yet to discuss interventions to keep similar incidents from happening again. She sated she was just worried about immediate treatment interventions for Resident #1. The DON stated she did not complete any other tasks to investigate Resident #1's fall incident on [DATE]. The DON stated on [DATE] she asked NA A to come to the facility to give a statement. The DON stated at that time she suspended NA A pending the outcome on the investigation. She stated she them spoke with the Administrator regarding NA A's statement of the incident. The DON stated that was all that she had completed for the investigation. She stated the investigation was still in progress. During an interview on [DATE] at 5: 23 p.m. RN B stated when she notified the DON, she did not have the information about Resident #1's feet getting stuck under the wheelchair, so she did not tell the DON that information. She stated she did not notify the DON after she learned this information because she documented it in Resident #1 nursing progress notes. RN B stated she put the details in the note for a reason and that reason was because the DON does an assessment after a fall occurs. RN B stated the DON would review the information and close the incident. RN B stated the DON typically reviewed a fall incident and closed it within 24 hours of occurrence. RN B stated as of the date and time of this interview neither the DON or the Administrator or any member of the management team had asked her what occurred during or after the incident and she had not been asked to write a witness statement. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:16 p.m. ADON G stated she was the Assistant Director of Nurses for the side of the building in which Resident #1 resided. She stated her job duties included overseeing everything on that side of the building and reporting any abuse/neglect concerns for allegations directly to the Administrator and DON. ADON G stated she was on a break on [DATE] at approximately 7:00 p.m. when RN B came and told her Resident #1 fell . ADON G stated RN B said NA A was pushing the resident when her feet got caught under the wheelchair causing her to fall and hit her head. She stated Resident #1 had a hematoma (swelling and bruising) to her forehead and was sent to a local ER but came back to the facility the same night at approximately 10:00 p.m. ADON G stated she did not provide any oversite to the fall incident, did not review Resident #1's nurses notes or medical record the next day. She stated she did go to morning meeting the next day on [DATE], but the incident was not discussed because the RP arrived at the facility and the Administrator and DON left the meeting to talk to her. ADON G stated neither the Administrator nor the DON came back to the meeting, so another staff member dismissed the meeting. ADON G stated as of the date and time of this interview she had not reviewed Resident #1's nursing notes, change of condition forms or anything related to the fall incident. She stated, I have not even looked at her chart. ADON G stated she did not review the incident because she was stuck on the floor training new staff. She stated since she was new to the ADON position she did not know what her job responsibilities entailed. ADON G stated she didn't know what her responsibility was and what she should leave for the DON. ADON G stated she did discuss with LVN E, NA A's comment I guess I could have pulled her back in the wheelchair first on the day of the incident ([DATE]). She stated she did not report the comment to the DON or the Administrator because it was hearsay. ADON G stated she did not have any concerns that needed to be reported because she had worked with NA A for a while and had never seen her do anything to harm a resident. ADON G stated no one from the management team had asked her what had occurred on [DATE] and she had not been asked to write a witness statement. During an interview on [DATE] at 12:45 p.m., the Administrator stated all fall incidents were discussed during meetings the next day. He stated the DON was responsible for reviewing fall incidents and accidents. The Administrator stated the DON had the ability to pull records, to look at lists and sometimes staff will notify her of the incident. The Administrator stated he was not notified of Resident #1's fall incident on [DATE]. He stated the first he heard of it was the following day, [DATE]. He stated he was notified that Resident #1 had a fall. He stated he asked if she had an injury, and someone (unknown staff) stated she hit her head on carpet when she fell forward and was to the ER because she was on blood thinners to rule out a brain bleed. He stated this occurred during morning meeting, which was interrupted because Resident #1's RP arrived at the facility. The Administrator stated Resident #1's fall incident was discussed during the meeting. The Administrator stated the DON looks at fall incidents every day. The Administrator stated a few days later the DON will ask him to lock the incident document. The Administrator stated the DON did her part on [DATE] and the document was reviewed and locked today ([DATE]). The Administrator stated he was not able to answer the question about time frame for reviewing and locking the documents because he would need to review the facility policy. The Administrator stated this incident took longer than typical to review because NA A was off the schedule and a surveyor was in the facility. The Administrator stated NA A stated she wished she would have done things differently, The Administrator stated he was not saying it was neglect, but it suggested we [the facility] failed to do something which caused an injury. The Administrator stated normally the DON would start the investigation right away, but the facility thought it was just a freak accident. The Administrator stated he was the facilities Abuse Coordinator. He stated he provided in-services on abuse/neglect to staff and encouraged staff to report things so he could assess the situation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy, titled Accidents/Incidents dated [DATE] revealed 1. An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident involving a Patient . Each Accident/Incident Report must be reviewed at the facility's daily stand-up meeting until all sections of the report are complete. Each Accident/Incident Report for an accident/incident occurring during a month must be signed by the Executive Director and Director of Nursing within 48 hours of the occurrence. 2. A witness statement must be completed at the time of the accident/incident. 14. The Executive Director serves as the Abuse Prevention Coordinator. In the absence of the Executive Director, the Director of Nursing or designee will fulfill the duties of the Abuse Prevention Coordinator. When an allegation of abuse or actual abuse is identified, the abuse protocol must be implemented. The Abuse Prevention Coordinator must complete a patient abuse investigation and conduct a thorough investigation of all patients involved. In addition, a plan of action must be implemented to prevent recurrence. Record review of a facility policy, titled Abuse Protocol dated [DATE] revealed: The Abuse Prevention Coordinator will a. Immediately (within 2 hours) report to The Department of Aging and Disability Services (DADS) [State Survey Agency/HHSC] .c. Conduct and document on a Patient Abuse Investigation a thorough investigation of each incident of Patient Abuse, neglect, exploitation or mistreatment to include: observations, interview and reviews of all patients involved, interview of all witnesses, including patients, staff and family members .recording all relevant physical findings.

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F 0689 Level of Harm - 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** 38511 Based on observation, interviews, and record reviews, the facility failed to ensure each resident received adequate supervision and assistive devices for 1 of 4 Residents (Resident #1) reviewed for accidents and hazards, in that: NA A failed to adequately supervise Resident #1 when she pushed her in the wheelchair which resulted in Resident #1 falling face first onto the ground hitting her face and head and requiring a trip to the emergency room for evaluation. This failure could place residents at risk of harm or injury and contribute to avoidable accidents. The findings were: Record review of Resident #1's face sheet dated [DATE] revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke). Generalized muscle weakness, vascular dementia without behavioral disturbance (a condition caused by lack of blood that carries oxygen to parts of the brain resulting in problems with reasoning, planning, judgment and memory), repeated falls, and paroxysmal atrial fibrillation (a heart condition with irregular heartbeat). Record review of Resident #1's physician orders dated [DATE] revealed an order for Eliquis (a blood thinner) 5 mg tablet two times a day for treatment of atrial fibrillation (a heart condition). Record review of Resident #1's Care Plan dated [DATE] revealed the resident had impaired cognition related to the diagnoses of vascular dementia with interventions which included: maintain consistent routine; introduce change slowly when possible to reduce confusion. Record review of Resident #1's Care Plan dated [DATE] revealed the resident was at risk for falls related to impaired cognition and a history of repeated falls, impaired vision and hearing .with interventions which included: assess reason for fall, staff education on proper positioning in the chair. Record review of Resident #1's quarterly assessment dated [DATE] revealed a BIMs of 5 (scale of , d+[DATE]) which indicated a severe cognitive impairment. Record review of Resident #1's quarterly assessment dated [DATE] revealed Resident #1 was unable to ambulate (walk) and required extensive assistance of staff to transfer, change position and move around the facility in a wheelchair. Record review of Resident #1's quarterly assessment dated [DATE] revealed Resident #1 was not steady and was only able to stabilize with staff assistance with balance during transitions. Record review of Resident #1's quarterly assessment dated [DATE] revealed Resident #1 had a history of two or more falls since admission. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #1's nursing progress notes dated [DATE] at 6:00 p.m. revealed: Reported by NA A, resident was sitting in wheelchair being pushed into bedroom by NA A. Residents feet were not lifted off the ground and got stuck under the chair: as stated by NA. Resident hit her forehead on the ground. No pain or discomfort noted, vital signs stable, resident does have carpet burn noted to forehead with increased swelling. Ice placed on resident's forehead. Notified NP, RP, and DON .orders to send out resident for a CT. Resident sent out of the building at 6:45 p.m.Documented by RN B. Record review of an accident/incident report dated [DATE] revealed Resident #1 had a witnessed fall from chair on [DATE] at 6:00 p.m. when Resident #1 was sitting in wheelchair pushed into bedroom by NA A. Resident #1's feet were not lifted off the ground and got stuck under the chair. Resident #1 hit her forehead on the ground .carpet burn noted to forehead with increased swelling. Resident #1 was sent to a local hospital emergency room for evaluation and treatment at 6:45 p.m. The primary injury was listed as contusions/hematoma, head involved. The DON was notified of the incident on [DATE] at 6:20 p.m. by RN B. Record review of Resident #'1 hospital record dated [DATE] revealed the results of a CT scan of the head and cervical spine which indicated the resident had small left para midline (left of midline or left side of forehead) frontal scalp edema and hematoma (swelling and bruising or collection of blood outside of the blood vessels typically caused by trauma) without fracture (break in bone) or intracranial change (changes inside the brain). Record review of Resident #1's nursing progress notes dated [DATE] at 12:59 a.m. revealed: Resident #1 returned from the local hospital alert/confused to place, time per usual. Abrasion to forehead open to air, neuro checks WNL (within normal limits) .no new orders received. Documented by LVN D. Record review of Resident #1's nursing progress notes dated [DATE] at 9:36 a.m. revealed Resident #1's RP (Responsible Party) here in facility to follow up post fall from yesterday evening. Resident denies discomfort. Resident able to make most needs known to staff .family requests to send Resident #1 out to a local hospital in an adjacent city. Documented by LVN C. During an interview on [DATE] at 3:43 p.m. LVN C stated on the morning on [DATE] she received in report (unknown staff) that Resident #1 was being pushed in a wheelchair on [DATE] during the evening shift when she fell forward. LVN C stated she did not know who was pushing Resident #1 in the wheelchair when the fall occurred. LVN C stated Resident #1's RP arrived at the facility on [DATE] shortly after 8:00 a.m. and as soon as she saw Resident #1, she became upset. LVN C stated Resident #1 had a bump on her forehead and was complaining of a little headache. LVN C stated she performed an assessment on the resident who presented as her normal appearance, with normal cognition for the resident at baseline with no acute changes. LVN C stated Resident #1 had normal vital signs and ate some of her breakfast. LVN C stated the RP spoke to several staff members (unknown) who told her Resident #1's CT exam was normal. LVN C stated the RP requested Resident #1 go to another hospital in an adjacent city for a second opinion. LVN C stated she notified the DON of the family's request and Resident #1 was sent to the hospital in an adjacent city per RP request. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:16 p.m. NA A stated on [DATE] at approximately 6:00 p.m. Resident #1 was self-propelling (using her feet to move herself in the wheelchair) down the hallway toward her room. NA A stated Resident #1 was not very far from her bedroom, approximately ,d+[DATE] doorway. NA A stated she needed to change Resident #1's brief, so she decided to push the resident the remainder of the way in the wheelchair. NA A stated she told Resident #1 let's go change you and began pushing the wheelchair forward. NA A stated she did not wait for the resident to respond to her because the resident did not normally respond. NA A stated Resident #1 was sitting forward on the seat of the wheelchair and was not sitting with her back against the backrest. NA A stated Resident #1's buttock and back were approximately 3 finger widths away from the back of the wheelchair. NA A stated, I should have pulled her back in the chair, but I didn't and when we turned the corner her feet got stuck underneath the wheelchair. NA A stated Resident #1 fell forward. She stated her feet went under the seat and she fell forward. NA A stated she tried to grab Resident #1's shirt, but it happened so quick. NA A stated Resident #1 fell forward and hit her forehead on the carpeted floor. NA A stated it happened so quick that Resident #1 was not able to put her arms out to stop or break the fall. NA A stated while pushing Resident #1 she noticed the resident was unable to hold her feet up while the wheelchair was moving. She stated Resident #1's feet kept going up and down. NA A stated she did not use footrests because Resident #1 does not have footrests on the wheelchair because she normally self-propels, and she needs them off the chair to be mobile. NA A stated, I should have pulled her back in her seat and this would not have happened, I know better than that. I go above and beyond for all my patients it was an accident and it happened so quick. NA A stated after Resident #1 fell she notified the ADON, identified as LVN E who assessed the resident. NA A stated Resident #1 stated she was okay even when the ambulance took her out of the facility. NA A stated no one from management had asked her to write a witness statement. NA A stated on [DATE] the DON asked her what had happened. NA A stated she told the DON the same thing she told stated in this interview. NA A stated after speaking to the DON she was sent home. She stated she completed new orientation competencies and training and had participated in lots of in-service trainings but could not remember what the trainings covered. She stated had participated in a resident movement training that address patient positioning, but she had not had any training specifically addressing pushing wheelchairs or wheelchair safety. NA A stated she had not been asked to complete or participate in any trainings since Resident #1's fall incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:55 p.m. LVN E stated she was the facilities Infection Preventionist and a member of the facility management team and a former ADON (as of [DATE]) for the facility. LVN E stated on [DATE] she was sitting in her office at approximately 6:00 p.m. LVN E stated Resident #1 peaked into her office to talk. LVN E stated Resident #1 who had dementia would often say hi and them move along the hallway by self-propelling in her wheelchair. LVN E stated she heard NA A if she wanted or needed to go to the bathroom and heard Resident #1 respond, yes. LVN E stated she looked up and saw the back of NA A pushing Resident #1 in the wheelchair towards her room. LVN E stated quickly after observing, NA A came and got her and stated Resident #1 had a fall. LVN E stated when she arrived at the resident, she was lying on the floor on her left side just inside the doorway to her room. LVN E stated she asked NA A Weren't you with her? LVN E stated NA A stated, Yes, but I could not catch her. LVN E stated she assessed Resident #1 and obtained vitals and then notified Resident #1's charge nurse, RN B stated Resident #1 had an abrasion to her forehead and she said her head hurt, but she did not have any other complaints of pain and she was alert. RN B. LVN E stated she told RN B to notify Resident #1's physician because Resident #1 was on blood thinner medication and had hit her head. LVN E stated she asked NA A what happened and NA A stated Resident #1 put her feet down while she was pushing her in the wheelchair. LVN E stated there were no witnesses. LVN E stated she felt like NA A could have handled the transport of Resident #1 better. She could have communicated better with the resident. LVN E stated was important, even for someone with dementia. LVN E stated Resident #1 tends to come forward in the seat of the wheelchair when self-propelling and NA A should have scooter her back in the wheelchair. LVN E stated she also could have allowed Resident #1 the time to finish self-propelling to her room and could have asked the resident to follow her to the bathroom instead of pushing her. LVN E stated Resident #1 was close to her room when the incident occurred and even if the resident did not go all the way by herself, NA A should have cued the resident. LVN E stated she didn't hear NA A cue the resident before the incident occurred. During an interview on [DATE] at 5:25 p.m. RN B stated on [DATE] at an unknown time near change of shift, she was notified by LVN E that Resident #1 had fallen. RN B stated Resident #1 was still on the floor when she arrived. She stated Resident #1 denied pain but had carpet burn and swelling to her forehead when EMS arrived at the facility. RN B stated she did not witness the incident, but asked NA A what happened. RN B stated, NA A said she was wheeling the resident to her room when Resident #1 fell forward headfirst and hit her head on the floor, immediately inside the resident room. RN B stated she notified ADON G and the DON of the incident on [DATE] (unknown time). RN B stated NA A did not tell her that until all the notifications were complete. RN B stated, Resident #1 cognition was normal, with no changes in baseline and was sent to the ER because she was on anticoagulants medication as a precaution only. RN B stated the DON told her to call 911. During an observation/interview on [DATE] at 8:30 a.m., Resident #1 was observed in a hospital bed at hospital in an adjacent city. Resident #1 had her eyes closed and did not open her eyes or respond to voice. Resident #1 was observed with a large bruise and swelling to her forehead, midline and to the left, with several small, scabbed areas and one large approximately 4 cm x 2 cm abrasion/open area to her forehead. Resident #1 also had bruising and swelling to both eyes and a small amount of bruising to her left cheekbone. (continued on next page)

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	676472	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway New Braunfels, TX 78130

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 8:44 a.m. with a RN at the hospital revealed Resident #1 had dementia and was unable to answer interview questions due to dementia and antipsychotic medication. The RN stated Resident #1 had repeat CT scans on [DATE] of her head which showed no abnormalities related to the fall incident. The RN stated the resident was being treated for a urinary tract infection and metabolic encephalopathy (a condition in which brain function is disturbed due to abnormalities of water, electrolytes, vitamins or other chemicals that adversely affect brain function). During an interview on [DATE] at 11:40 a.m. the DON stated she was notified of Resident #1's fall incident by an unknown staff member on an unknown date and time. The DON stated she was informed Resident #1 hit her head and the staff was sending her out because she was on blood thinners to make sure she didn't have a brain bleed. The DON stated on [DATE] Resident #1's RP came to the facility and was upset. The DON stated, the Administrator and herself spoke with the RP. The DON stated the RP was crying and extremely distraught because she had another elderly relative who had died , she herself had not been feeling well and now her family member had fallen. The DON stated the RP kept saying She is all that I have left in this world. The DON stated they went over the CT scan results which were negative, but the RP still wanted Resident #1 transported to a hospital in an adjacent city for a second opinion. The DON stated the RP wanted to know what happened to her family member. The DON stated she informed the RP that as far as she knew it was a fall. She said she told the RP she would look into it and get back in contact with her. The DON stated she had other issues at the facility on [DATE] to address. On [DATE] a state surveyor was in the facility which changed her day. The DON stated on [DATE] she looked through fall reports again and asked NA A to come give a statement. The DON stated after speaking with NA A she gave the aide a training on positioning and transferring and she suspended NA A because she had not finished her investigation. The DON stated as of [DATE] she would begin an on-going in-service about something she that needed to be reiterated with staff. The DON stated she needed to finish her investigation before commenting further. The DON stated she had not reviewed Resident #1's medical records at the time of this interview. The DON stated patient safety is always priority when transporting a resident in a wheelchair. She stated she did not know what the facilities policies and procedures were for wheelchair use. She stated she would have to look into it, but staff should make sure residents were positioned correctly, back on the chair, feet out and if the resident could not hold their feet up, staff should use footrests. The DON stated proper positing in the wheelchair was important, so residents and staff did not get hurt. During an interview on [DATE] at 5: 23 p.m. RN B stated when she notified the DON, she did not have the information about Resident #1's feet getting stuck under the wheelchair, so she did not tell the DON that information. She stated she did not notify the DON after she learned this information because she documented it in Resident #1 nursing progress notes. RN B stated she put the details in the note for a reason and that reason was because the DON does an assessment after a fall occurs. RN B stated the DON would review the information and close the incident. RN B stated the DON typically reviewed a fall incident and closed it within 24 hours of occurrence. RN B stated as of the date and time of this interview neither the DON or the Administrator or any member of the management team had asked her what occurred during or after the incident and she had not been asked to write a witness statement. RN B stated she had had not had any training since the fall incident with Resident #1. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 4:16 p.m. ADON G stated she was the Assistant Director of Nurses for the side of the building in which Resident #1 resided. She stated her job duties included overseeing everything on that side of the building and reporting any abuse/neglect concerns for allegations directly to the Administrator and DON. ADON G stated she was on a break on [DATE] at approximately 7:00 p.m. when RN B came and told her Resident #1 fell . ADON G stated RN B said NA A was pushing the resident when her feet got caught under the wheelchair causing her to fall and hit her head. ADON G stated she was concerned because Resident #1 was on Eliquis (a blood thinner). She stated Resident #1 had a hematoma (swelling and bruising) to her forehead and was sent to a local ER but came back to the facility the same night at approximately 10:00 p.m. ADON G stated there was no change to Resident #1 cognitive status. She stated since she was new to the ADON position she did not know what her job responsibilities entailed. ADON G stated she didn't know what her responsibility was and what she should leave for the DON. ADON G stated she did discuss with LVN E, NA A's comment I guess I could have pulled her back in the wheelchair first on the day of the incident ([DATE]). She stated she did not report the comment to the DON or the Administrator because it was hearsay. ADON G stated she did not have any concerns that needed to be reported because she had worked with NA A for a while and had never seen her do anything to harm a resident. During an interview on [DATE] at 5:50 p.m. the DON stated she trained staff to ask the residents to pick up their legs during wheelchair movement. The DON stated if a resident was unable to hold up their legs, then leg rests should be used or alternately another staff member could hold up the resident's legs, although it was not good mechanics. The DON stated there was no training specific to proper use of a wheelchair. The staff training was geared most towards resident transfer. The DON stated the training given to NA A was resident transfer and proper positioning in a chair. The DON stated she monitored staff for proper use of a wheelchair and proper positioning by watching staff and rounding constantly. She stated she watches staff by watching them change the resident, answer the call lights, monitor the state of the resident rooms and how the resident and their skin looks. The DON stated she did not have a monitoring program for proper wheelchair use, short of the education staff received during orientation which included transfer training, there was no specific competency for wheelchair use. The DON stated she ensured staff was using a wheelchair appropriately by observing. She stated it is wheelchair, staff are not supposed to be running down the hall. She stated a wheelchair has two brakes one on each side, handles on the back and a seat, and staff push it forward. The DON stated customized wheelchairs require training because they are specific to the resident. The DON stated Resident #1 did not have a customized wheelchair. She stated there was nothing special about it. The DON stated she helped staff all the time. She stated if she saw a resident who was not properly positioned in the wheelchair, she would help reposition the resident. The DON stated she communicated with other members of the management team including the Administrator during morning and afternoon meetings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:45 p.m., the Administrator stated/ fall incidents were discussed during meetings the next day. He stated the DON was responsible for reviewing fall incidents and accidents. The Administrator stated the DON had the ability to pull records, to look at lists and sometimes staff will notify her of the incident. The Administrator stated he was not notified of Resident #1's fall incident on [DATE]. He stated the first he heard of it was the following day, [DATE]. He stated he was notified that Resident #1 had a fall. He stated he asked if she had an injury, and someone (unknown staff) stated she hit her head on carpet when she fell forward and was to the ER because she was on blood thinners to rule out a brain bleed. He stated this occurred during morning meeting, which was interrupted because Resident #1's RP arrived at the facility. The Administrator stated Resident #1's fall incident was discussed during the meeting. The Administrator stated the DON looks at fall incidents every day and then makes recommendations for interventions. The Administrator stated NA A stated she wished she would have done things differently, The Administrator stated he was not saying it was neglect, but it suggested we failed to do something which caused an injury. The Administrator stated normally the DON would start the investigation right away, but the facility thought it was just a freak accident. Record review of a safety information on www.eliquis.bmscustomerconnect.com by the manufacturer of Eliquis (a blood thinner) reviewed on [DATE] revealed: Eliquis can cause bleeding, which can be serious, and rarely may lead to death. This is because Eliquis is a blood thinner medicine that reduces blood clotting. While taking Eliquis, you may bruise more easily, and it may take longer than usual for any bleeding to stop. Record review of a facility policy, titled Wheelchair-use of dated [DATE]. 2006 and last revised ,d+[DATE] revealed: Assist patient into wheelchair, using proper transfer techniques. Lower footrests and place patient's feet on footrests. Position feet and legs in good body alignment. Assist patient to the area of the facility as desired. Encourage and instruct patient in proper procedures for safety propelling the wheelchair. Record review of a facility policy, titled Accidents/Incidents dated [DATE] revealed 1. An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident involving a Patient and, if necessary, the patients Care Plan must be updated. Each Accident/Incident Report must be reviewed at the facility's daily stand-up meeting until all sections of the report are complete. Each Accident/Incident Report for an accident/incident occurring during a month must be signed by the Executive Director and Director of Nursing within 48 hours of the occurrence. 2. A witness statement must be completed at the time of the accident/incident.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 of 4 residents (Resident #1) reviewed for wheelchair use, in that; NA A failed to transport Resident #1 in a wheelchair in a safe manner, resulting in a fall incident for Resident #1. This failure could place residents who use a wheelchair and place them at risk for injury. The findings were: Record review of Resident #1's face sheet dated 06/08/2022 revealed an [AGE] year-old female admitted on [DATE] with diagnoses which included: cerebral infarction (stroke). Generalized muscle weakness, vascular dementia without behavioral disturbance (a condition caused by lack of blood that carries oxygen to parts of the brain resulting in problems with reasoning, planning, judgment and memory), repeated falls, and paroxysmal atrial fibrillation (a heart condition with irregular heartbeat). Record review of Resident #1's Care Plan dated 4/24/2021 revealed the resident had impaired cognition related to the diagnoses of vascular dementia with interventions which included: maintain consistent routine; introduce change slowly when possible to reduce confusion. Record review of Resident #1's Care Plan dated 4/24/2021 revealed the resident was at risk for falls related to impaired cognition and a history of repeated falls, impaired vision and hearing .with interventions which included: assess reason for fall, staff education on proper positioning in the chair. Record review of Resident #1's quarterly assessment dated [DATE] revealed a BIMs of 5 (scale of 0-15) which indicated a severe cognitive impairment. Record review of Resident #1's quarterly assessment dated [DATE] of the resident's functional status revealed Resident #1 was unable to ambulate (walk) and required extensive assistance of staff to transfer, change position and move around the facility in a wheelchair. Record review of Resident #1's nursing progress notes dated 06/06/2022 at 6:00 p.m. revealed: Reported by NA A, resident was sitting in wheelchair being pushed into bedroom by NA A. Residents feet were not lifted off the ground and got stuck under the chair: as stated by NA. Resident hit her forehead on the ground. No pain or discomfort noted, vital signs stable, resident does have carpet burn noted to forehead with increased swelling. Ice placed on resident's forehead. Notified NP, RP, and DON .orders to send out resident for a CT. Resident sent out of the building at 6:45 p.m.Documented by RN B. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an accident/incident report dated 6/06/2022 revealed Resident #1 had a witnessed fall from chair on 6/06/2022 at 6:00 p.m. when Resident #1 was sitting in wheelchair pushed into bedroom by NA A. Resident #1's feet were not lifted off the ground and got stuck under the chair. Resident #1 hit her forehead on the ground .carpet burn noted to forehead with increased swelling. Resident #1 was sent to a local hospital emergency room for evaluation and treatment at 6:45 p.m. The primary injury was listed as contusions/hematoma, head involved. The DON was notified of the incident on 6/06/2022 at 6:20 p.m. by RN B. Record review of Resident #'1 hospital record dated 6/06/2022 revealed the results of a CT scan of the head and cervical spine which indicated the resident had small left para midline (left of midline or left side of forehead) frontal scalp edema and hematoma (swelling and bruising or collection of blood outside of the blood vessels typically caused by trauma) without fracture (break in bone) or intracranial change (changes inside the brain). During an interview on 6/08/2022 at 3:43 p.m. LVN C stated on the morning on 6/07/2022 she received in report (unknown staff) that Resident #1 was being pushed in a wheelchair on 6/06/2022 during the evening shift when she fell forward. LVN C stated she did not know who was pushing Resident #1 in the wheelchair when the fall occurred. LVN C stated Resident #1 had a bump on her forehead and was complaining of a little headache. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/08/2022 at 4:16 p.m. NA A stated on 6/06/2022 at approximately 6:00 p.m. Resident #1 was self-propelling (using her feet to move herself in the wheelchair) down the hallway toward her room. NA A stated Resident #1 was not very far from her bedroom, approximately 2-3 doorway. NA A stated she needed to change Resident #1's brief, so she decided to push the resident the remainder of the way in the wheelchair. NA A stated she told Resident #1 let's go change you and began pushing the wheelchair forward. NA A stated she did not wait for the resident to respond to her because the resident did not normally respond. NA A stated Resident #1 was sitting forward on the seat of the wheelchair and was not sitting with her back against the backrest. NA A stated Resident #1's buttock and back were approximately 3 finger widths away from the back of the wheelchair. NA A stated, I should have pulled her back in the chair, but I didn't and when we turned the corner her feet got stuck underneath the wheelchair. NA A stated Resident #1 fell forward. She stated her feet went under the seat and she fell forward. NA A stated she tried to grab Resident #1's shirt, but it happened so quick. NA A stated Resident #1 fell forward and hit her forehead on the carpeted floor. NA A stated it happened so quick that Resident #1 was not able to put her arms out to stop or break the fall. NA A stated while pushing Resident #1 she noticed the resident was unable to hold her feet up while the wheelchair was moving. She stated Resident #1's feet kept going up and down. NA A stated she did not use footrests because Resident #1 does not have footrests on the wheelchair because she normally self-propels, and she needs them off the chair to be mobile. NA A stated, I should have pulled her back in her seat and this would not have happened, I know better than that. I go above and beyond for all my patients it was an accident and it happened so quick. NA A stated after Resident #1 fell she notified the ADON, identified as LVN E who assessed the resident. NA A stated Resident #1 stated she was okay even when the ambulance took her out of the facility. NA A stated no one from management had asked her to write a witness statement. NA A stated on 6/07/2022 the DON asked her what had happened. NA A stated she told the DON the same thing she told stated in this interview. NA A stated after speaking to the DON she was sent home. She stated she completed new orientation competencies and training and had participated in lots of in-service trainings but could not remember what the trainings covered. She stated had participated in a resident movement training that address patient positioning, but she had not had any training specifically addressing pushing wheelchairs or wheelchair safety. NA A stated she had not been asked to complete or participate in any trainings since Resident #1's fall incident. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/08/2022 at 4:55 p.m. LVN E stated she was the facility's Infection Preventionist and a member of the facility management team and a former ADON (as of January 2022) for the facility. LVN E stated on 6/06/2022 she was sitting in her office at approximately 6:00 p.m. LVN E stated Resident #1 peaked into her office to talk. LVN E stated Resident #1 who had dementia would often say hi and then move along the hallway by self-propelling in her wheelchair. LVN E stated she heard NA A ask if she wanted or needed to go to the bathroom and heard Resident #1 respond, yes. LVN E stated she looked up and saw the back of NA A pushing Resident #1 in the wheelchair towards her room. LVN E stated quickly after observing, NA A came and got her and stated Resident #1 had a fall. LVN E stated when she arrived at the resident, she was lying on the floor on her left side just inside the doorway to her room. LVN E stated she asked NA A Weren't you with her? LVN E stated NA A stated, Yes, but I could not catch her. LVN E stated she assessed Resident #1 and obtained vitals and then notified Resident #1's charge nurse, RN B stated Resident #1 had an abrasion to her forehead and she said her head hurt, but she did not have any other complaints of pain and she was alert. RN B. LVN E stated she told RN B to notify Resident #1's physician because Resident #1 was on blood thinner medication and had hit her head. LVN E stated she asked NA A what happened and NA A stated Resident #1 put her feet down while she was pushing her in the wheelchair. LVN E stated there were no witnesses. LVN E stated she felt like NA A could have handled the transport of Resident #1 better. She could have communicated better with the resident. LVN E stated was important, even for someone with dementia. LVN E stated Resident #1 tends to come forward in the seat of the wheelchair when self-propelling and NA A should have scooter her back in the wheelchair. LVN E stated she also could have allowed Resident #1 the time to finish self-propelling to her room and could have asked the resident to follow her to the bathroom instead of pushing her. LVN E stated Resident #1 was close to her room when the incident occurred and even if the resident did not go all the way by herself, NA A should have cued the resident. LVN E stated she didn't hear NA A cue the resident before the incident occurred. During an interview on 6/08/2022 at 5:25 p.m. RN B stated on 6/06/2022 at an unknown time near change of shift, she was notified by LVN E that Resident #1 had fallen. RN B stated Resident #1 was still on the floor when she arrived. She stated Resident #1 denied pain but had carpet burn and swelling to her forehead when EMS arrived at the facility. RN B stated she did not witness the incident, but asked NA A what happened. RN B stated, NA A said she was wheeling the resident to her room when Resident #1 fell forward headfirst and hit her head on the floor, immediately inside the resident room. RN B stated she notified ADON G and the DON of the incident on 6/06/2022 (unknown time). RN B stated NA A did not tell her that until all the notifications were complete. RN B stated, Resident #1 cognition was normal, with no changes in baseline and was sent to the ER because she was on anticoagulant medication as a precaution only. RN B stated the DON told her to call 911. During an observation/interview on 6/09/2022 at 8:30 a.m., Resident #1 was observed in a hospital bed at hospital in an adjacent city. Resident #1 had her eyes closed and did not open her eyes or respond to voice. Resident #1 was observed with a large bruise and swelling to her forehead, midline and to the left, with several small, scabbed areas and one large approximately 4 cm x 2 cm abrasion/open area to her forehead. Resident #1 also had bruising and swelling to both eyes and a small amount of bruising to her left cheekbone. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/09/2022 at 11:40 a.m. the DON stated she was notified of Resident #1's fall incident by an unknown staff member on an unknown date and time. The DON stated she was informed Resident #1 hit her head and the staff was sending her out because she was on blood thinners to make sure she didn't have a brain bleed. The DON stated she had other issues at the facility on 6/07/2022 to address. On 6/08/2022 a state surveyor was in the facility which changed her day. The DON stated on 6/09/2022 she looked through fall reports again and asked NA A to come give a statement. The DON stated she had not reviewed Resident #1's medical records at the time of this interview. The DON stated patient safety was always priority when transporting a resident in a wheelchair. She stated she did not know what the facility's policies and procedures were for wheelchair use. She stated she would have to look into it, but staff should make sure residents were positioned correctly, back on the chair, feet out and if the resident could not hold their feet up, staff should use footrests. The DON stated proper positing in the wheelchair was important, so residents and staff did not get hurt. During an interview on 6/09/2022 at 4:16 p.m. ADON G stated she was the Assistant Director of Nurses for the side of the building in which Resident #1 resided. She stated her job duties included overseeing everything on that side of the building and reporting any abuse/neglect concerns for allegations directly to the Administrator and DON. ADON G stated she was on a break on 6/06/2022 at approximately 7:00 p.m. when RN B came and told her Resident #1 fell . ADON G stated RN B said NA A was pushing the resident when her feet got caught under the wheelchair causing her to fall and hit her head. During an interview on 6/09/2022 at 5:50 p.m. the DON stated she trains staff to ask the residents to pick up their legs during wheelchair movement. The DON stated if a resident was unable to hold up their legs, then leg rests should be used or alternately another staff member could hold up the resident's legs, although it was not good mechanics. The DON stated there was no training specific to proper use of a wheelchair. The staff training was geared most towards resident transfer. The DON stated the training given to NA A was resident transfer and proper positioning in a chair. The DON stated she did not have a monitoring program for proper wheelchair use, short of the education staff received during orientation which included transfer training, there was no specific competency for wheelchair use. The DON stated she ensured staff was using a wheelchair appropriately by observing. She stated it is wheelchair, staff are not supposed to be running down the hall. She stated a wheelchair has two brakes one on each side, handles on the back and a seat, and staff push it forward. The DON stated customized wheelchairs require training because they are specific to the resident. The DON stated Resident #1 did not have a customized wheelchair. She stated there was nothing special about it. Record review an in-service training record titled Sensitivity Training dated 4/12/2022-4/13/2022 revealed NA A had signed the attendance record for training which covered: definitions of abuse, signs of abuse, and staff behavior towards and around residents. Record review of NA A competencies dated 12/29/2021 revealed there was no specific competency which addressed proper or safe use of a wheelchair or transporting and/or positioning of residents in a wheelchair. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676472	A. Building B. Wing	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Inn Health Center	2034 Sundance Parkway New Braunfels, TX 78130

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of NA A training records revealed she had completed a training titled Preventing slips, Trips and Falls on 11/30/2021, Transferring-Mechanical Lifts on 12/31/2021 and Understanding Abuse and Neglect on 4/30/2022. There was no training that specifically addressed proper or safe use of a wheelchair or transporting and/or positioning of residents in a wheelchair. Record review of a facility policy, titled Wheelchair-use of dated June 14. 2006 and last revised 07/2014 revealed: Assist patient into wheelchair, using proper transfer techniques. Lower footrests and place patient's feet on footrests. Position feet and legs in good body alignment. Assist patient to the area of the facility as desired. Encourage and instruct patient in proper procedures for safety propelling the wheelchair. Record review of a facility policy, titled Personnel dated November 2017 revealed: 8. The facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, psychosocial well-being of each patient, as determined by assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's patient population in accordance with the facility assessment.