STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER: Payson Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 107 East Lone Pine Drive, Payson, AZ 85541	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51006 Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure that two residents (Resident #104 and Resident #400) do not abuse each other. The deficient practice could result in further instances of resident to resident altercations, creating an unsafe environment. - In regards to Resident #104 Resident #104 was readmitted to the facility on [DATE] with the diagnosis of post-traumatic stress disorder, unspecified, anxiety disorder, unspecified, vascular dementia, severe, with other behavioral disturbance, other amnesia, sensorineural hearing loss, bilateral, cognitive communication deficit. A quarterly MDS (minimum data set) dated March 25, 2022 revealed a BIMS (Brief Interview for Mental Status) score of 00, indicating that Resident #104 had the most severe level of cognitive impairment, signifying a person has demonstrated very poor cognitive function on the Brief Interview for Mental Status (BIMS) test, essentially showing a lack of ability to answer basic cognitive questions correctly. A progress note created on May 24, 2022 revealed an alleged event between Resident #104 and Resident #400, stating Resident #400 punched Resident #104 in the left shoulder, and, Resident #400 attempted to push Resident #104 until being separated by a CNA (certified nursing assistant). There are no other assessments indicating that a reviewed Resident #104's cognition or psychosocial and physical harm following the alleged incident. A review of intake documentation following an alleged event on May 24, 2022 revealed that an incomplete reportable event record/report had been provided to the Department of Health Services on May 26, 2022. The record did not include documentation supporting the facilities investigation, indicating an incomplete report of the facilities investigation. The record did reveal that a CNA witnessed the alleged event between Resident #104 and Resident #400 and that five other staff members were interviewed. No other documentation and evidence were included in the report review. A phone interview with a previous employed LPN (Licensed Practical Nurse/Staff #63) was attempted on March 5, 2025 at 1:31PM but were unsuccessful as she did not respond or return the call. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN (staff #36) on March 5, 2025 at 1:36PM was conducted and stated that she worked the floor in May of 2022. After a review of Resident #104 and Resident #400's charts, Staff #36 re-called both residents were observed with exit seeking behaviors and verbal aggression. Staff #36 recalled Resident #104 also exhibited physical aggression, however, easily re-directable with hands on activities and tasks to stimulate their previous work that involved handy work (mechanic). In regards to any resident to resident altercations, Staff #36 reported that any altercations between the two residents are plausible as both residents were ambulatory and independently moved about the unit. A phone interview with a previous employed CNA (Staff #16) was attempted on March 5, 2025 at 2:10PM but were unsuccessful as she did not respond or return the call. A phone interview with a previous employed CNA (Staff #64) on March 5, 2025 at 2:13PM was conducted and stated that they worked the floor during Mat 2022 and was assigned to no specific unit. Staff #64 stated that he re-called that Resident #104 exhibited exit seeking behaviors that resulted into physical and verbal aggression when not re-directed. Staff #64 stated that Resident #104 did not talk to other residents much so if an altercation did occur between Resident #104 and another resident, that Resident #104 could have been experiencing an 'off day', and that these 'off-days' have escalated to physical aggression when provoked. In an interview on March 7, 2025 at 9:33AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed Staff #62's understanding of identifying, reporting, and investigating alleged incidents. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of potential resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation. In an interview on March 7, 2025 at 9:35AM with the executive director (Staff #65) revealed Staff #65's understanding of identifying, reporting, and investigating alleged incidents, as a mandated reporter. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of further resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation. - In regards to Resident #400 Resident #400 admitted to the facility on [DATE] with the diagnosis of Non-Alzheimer's Dementia and cognitive communication deficit. A quarterly MDS (minimum data set) dated April 6, 2022 revealed a BIMS (Brief Interview for Mental Status) score of 00, indicating that Resident #400 had the most severe level of cognitive impairment, signifying a person has demonstrated very poor cognitive function on the Brief Interview for Mental Status (BIMS) test, essentially showing a lack of ability to answer basic cognitive questions correctly. A progress note created on May 24, 2022 revealed an alleged event between Resident #104 and Resident #400, stating Resident #400 punched Resident #104 in the left shoulder, and, Resident #400 attempted to push Resident #104 until being separated by a CNA (certified nursing assistant). Indicating that there had been a verbal and physical altercation between Resident #104 and Resident #400. (continued on next page)

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

There are no other assessments indicating that a reviewed Resident #400's cognition or psychosocial and physical harm following the alleged incident.

A review of intake documentation following an alleged event on May 24, 2022 revealed that an incomplete reportable event record/report had been provided to the Department of Health Services on May 26, 2022. The record did not include documentation supporting the facilities investigation, indicating an incomplete report of the facilities investigation. The record did reveal that a CNA witnessed the alleged event between Resident #104 and Resident #400 and that five other staff members were interviewed. No other documentation and evidence were included in the report review.

A phone interview with a previous employed LPN (Licensed Practical Nurse/Staff #63) was attempted on March 5, 2025 at 1:31PM but were unsuccessful as she did not respond or return the call.

An interview with LPN (staff #36) on March 5, 2025 at 1:36PM was conducted and stated that she worked the floor in May of 2022. After a review of Resident #104 and Resident #400's charts, Staff #36 re-called both residents were observed with exit seeking behaviors and verbal aggression. Staff #36 recalled Resident #104 also exhibited physical aggression, however, easily re-directable with hands on activities and tasks to stimulate their previous work that involved handy work (mechanic). In regards to any resident to resident altercations, Staff #36 reported that any altercations between the two residents are plausible as both residents were ambulatory and independently moved about the unit.

A phone interview with a previous employed CNA (Staff #16) was attempted on March 5, 2025 at 2:10PM but were unsuccessful as she did not respond or return the call.

A phone interview with a previous employed CNA (Staff #64) on March 5, 2025 at 2:13PM was conducted and stated that they worked the floor during Mat 2022 and was assigned to no specific unit. Staff #64 stated that he re-called that Resident #104 exhibited exit seeking behaviors that resulted into physical and verbal aggression when not re-directed. Staff #64 stated that Resident #104 did not talk to other residents much so if an altercation did occur between Resident #104 and another resident, that Resident #104 could have been experiencing an 'off day', and that these 'off-days' have escalated to physical aggression when provoked.

In an interview on March 7, 2025 at 9:33AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed Staff #62's understanding of identifying, reporting, and investigating alleged incidents. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of potential resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation.

In an interview on March 7, 2025 at 9:35AM with the executive director (Staff #65) revealed Staff #65's understanding of identifying, reporting, and investigating alleged incidents, as a mandated reporter. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of further resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Abuse-Identification of Types revealed that the facility defined risk factors that may provoke reactions in residents, staff or visitors which included verbally aggressive behaviors, physical aggressive behaviors, and wandering behaviors. The policy also revealed the facility's definition of abuse, which included the willful infliction of injury.

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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** 51006 Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure that documentation and evidence of an investigation of an alleged incident between two residents (Resident #104 and Resident #400) were retained as evidence of a thorough investigation had been completed. The deficient practice could result in further instances inadequate investigation completion and documentation retention of completed investigations. - In regards to Resident #104 Resident #104 was readmitted to the facility on [DATE] with the diagnosis of post-traumatic stress disorder, unspecified, anxiety disorder, unspecified, vascular dementia, severe, with other behavioral disturbance, other amnesia, sensorineural hearing loss, bilateral, cognitive communication deficit. A quarterly MDS (minimum data set) dated March 25, 2022 revealed a BIMS (Brief Interview for Mental Status) score of 00, indicating that Resident #104 had the most severe level of cognitive impairment, signifying a person has demonstrated very poor cognitive function on the Brief Interview for Mental Status (BIMS) test, essentially showing a lack of ability to answer basic cognitive questions correctly. A progress note created on May 24, 2022 revealed an alleged event between Resident #104 and Resident #400, stating Resident #400 punched Resident #104 in the left shoulder, and, Resident #400 attempted to push Resident #104 until being separated by a CNA (certified nursing assistant). There are no other assessments indicating that a reviewed Resident #104's cognition or psychosocial and physical harm following the alleged incident. A review of intake documentation following an alleged event on May 24, 2022 revealed that an incomplete reportable event record/report had been provided to the Department of Health Services on May 26, 2022. The record did not include documentation supporting the facilities investigation, indicating an incomplete report of the facilities investigation. The record did reveal that a CNA witnessed the alleged event between Resident #104 and Resident #400 and that five other staff members were interviewed. No other documentation and evidence were included in the report review. On March 5, 2025 a record request was submitted to the facility at 11:30AM to provide documentation of the alleged incident between Resident #104 and Resident #400 in the month of May in 2022. In an interview on March 5, 2025 at 1:13PM with the executive director (Staff #65) revealed that the facility was unable to provide documentation of the alleged incident and the investigation of the incident that occurred between Resident #104 and Resident #400. Indicating that the facility failed to complete a thorough investigation and retain documentation and evidence of what was investigated. A phone interview with a previous employed LPN (Licensed Practical Nurse/Staff #63) was attempted on March 5, 2025 at 1:31PM but were unsuccessful as she did not respond or return the call. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN (staff #36) on March 5, 2025 at 1:36PM was conducted and stated that she worked the floor in May of 2022. After a review of Resident #104 and Resident #400's charts, Staff #36 re-called both residents were observed with exit seeking behaviors and verbal aggression. Staff #36 recalled Resident #104 also exhibited physical aggression, however, easily re-directable with hands on activities and tasks to stimulate their previous work that involved handy work (mechanic). In regards to any resident to resident altercations, Staff #36 reported that any altercations between the two residents are plausible as both residents were ambulatory and independently moved about the unit. A phone interview with a previous employed CNA (Staff #16) was attempted on March 5, 2025 at 2:10PM but were unsuccessful as she did not respond or return the call. A phone interview with a previous employed CNA (Staff #64) on March 5, 2025 at 2:13PM was conducted and stated that they worked the floor during Mat 2022 and was assigned to no specific unit. Staff #64 stated that he re-called that Resident #104 exhibited exit seeking behaviors that resulted into physical and verbal aggression when not re-directed. Staff #64 stated that Resident #104 did not talk to other residents much so if an altercation did occur between Resident #104 and another resident, that Resident #104 could have been experiencing an 'off day', and that these 'off-days' have escalated to physical aggression when provoked. In an interview on March 7, 2025 at 9:33AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed Staff #62's understanding of identifying, reporting, and investigating alleged incidents. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of potential resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation. In an interview on March 7, 2025 at 9:35AM with the executive director (Staff #65) revealed Staff #65's understanding of identifying, reporting, and investigating alleged incidents, as a mandated reporter. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of further resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation. - In regards to Resident #400 Resident #400 admitted to the facility on [DATE] with the diagnosis of Non-Alzheimer's Dementia and cognitive communication deficit. A quarterly MDS (minimum data set) dated April 6, 2022 revealed a BIMS (Brief Interview for Mental Status) score of 00, indicating that Resident #400 had the most severe level of cognitive impairment, signifying a person has demonstrated very poor cognitive function on the Brief Interview for Mental Status (BIMS) test, essentially showing a lack of ability to answer basic cognitive questions correctly. A progress note created on May 24, 2022 revealed an alleged event between Resident #104 and Resident #400, stating Resident #400 punched Resident #104 in the left shoulder, and, Resident #400 attempted to push Resident #104 until being separated by a CNA (certified nursing assistant). Indicating that there had been a verbal and physical altercation between Resident #104 and Resident #400. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

There are no other assessments indicating that a reviewed Resident #400's cognition or psychosocial and physical harm following the alleged incident.

A review of intake documentation following an alleged event on May 24, 2022 revealed that an incomplete reportable event record/report had been provided to the Department of Health Services on May 26, 2022. The record did not include documentation supporting the facilities investigation, indicating an incomplete report of the facilities investigation. The record did reveal that a CNA witnessed the alleged event between Resident #104 and Resident #400 and that five other staff members were interviewed. No other documentation and evidence were included in the report review.

A phone interview with a previous employed LPN (Licensed Practical Nurse/Staff #63) was attempted on March 5, 2025 at 1:31PM but were unsuccessful as she did not respond or return the call.

An interview with LPN (staff #36) on March 5, 2025 at 1:36PM was conducted and stated that she worked the floor in May of 2022. After a review of Resident #104 and Resident #400's charts, Staff #36 re-called both residents were observed with exit seeking behaviors and verbal aggression. Staff #36 recalled Resident #104 also exhibited physical aggression, however, easily re-directable with hands on activities and tasks to stimulate their previous work that involved handy work (mechanic). In regards to any resident to resident altercations, Staff #36 reported that any altercations between the two residents are plausible as both residents were ambulatory and independently moved about the unit.

On March 5, 2025 a record request was submitted to the facility at 11:30AM to provide documentation of the alleged incident between Resident #104 and Resident #400 in the month of May in 2022.

In an interview on March 5, 2025 at 1:13PM with the executive director (Staff #65) revealed that the facility was unable to provide documentation of the alleged incident and the investigation of the incident that occurred between Resident #104 and Resident #400. Indicating that the facility failed to complete a thorough investigation and retain documentation and evidence of what was investigated.

A phone interview with a previous employed CNA (Staff #16) was attempted on March 5, 2025 at 2:10PM but were unsuccessful as she did not respond or return the call.

A phone interview with a previous employed CNA (Staff #64) on March 5, 2025 at 2:13PM was conducted and stated that they worked the floor during Mat 2022 and was assigned to no specific unit. Staff #64 stated that he re-called that Resident #104 exhibited exit seeking behaviors that resulted into physical and verbal aggression when not re-directed. Staff #64 stated that Resident #104 did not talk to other residents much so if an altercation did occur between Resident #104 and another resident, that Resident #104 could have been experiencing an 'off day', and that these 'off-days' have escalated to physical aggression when provoked.

In an interview on March 7, 2025 at 9:33AM with interim director of nursing (Staff # 39) and regional director of clinical services (Staff #62) revealed Staff #62's understanding of identifying, reporting, and investigating alleged incidents. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of potential resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation.

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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	In an interview on March 7, 2025 at 9:35AM with the executive director (Staff #65) revealed Staff #65's understanding of identifying, reporting, and investigating alleged incidents, as a mandated reporter. Revealing that the facilities expectation is to ensure that the chain of command is notified of the investigation and its results, with the risk of further resident harm is the expectations set by the facility is not executed, especially, an inappropriate completion of an investigation. A policy titled, Abuse-Identification of Types revealed that the facility defined risk factors that may provoke reactions in residents, staff or visitors which included verbally aggressive behaviors, physical aggressive behaviors, and wandering behaviors. The policy also revealed the facility's definition of abuse, which included the willful infliction of injury. A policy titled, Abuse-Conducting an Investigation revealed that the facility must thoroughly collect evidence to allow the administrator or designee to determine what actions are necessary for the protection of residents. The policy also revealed that the administrator or designee will review the incident report for completeness and obtain a written summary of the investigation in accordance with state and federal regulations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** 50887 Based on documentation, staff interviews, and facility policy and procedures, the facility failed to ensure one resident (#18) was provided with adequate supervision to prevent falls. The deficient practice could result in residents being harmed physically. Findings include: Resident #18 was admitted to the facility on [DATE] with diagnoses that included, pain in thoracic spine, pain in left and right leg, age related osteoporosis, and other abnormalities of gait and mobility. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 11, indicating moderate cognitive impairment. The assessment also revealed that the facility was unable to determine falls in the last month prior to admission or last 2-6 months of admission, but indicated the resident did not have any falls since admission. Review of the resident's care plan revealed no evidence of a focus or interventions related to falls prior to or after each documented fall. Review of the resident's clinical record revealed that the resident had falls in the facility on the following dates: -2 falls on January 28, 2025 -1 fall on February 2, 2025 -1 fall on February 8, 2025 -1 fall on February 9, 2025 An event note dated January 28, 2025 at 10:45 PM revealed that the nurse was called to the resident's room by a certified nursing assistant (CNA) to find the resident sitting upright on the floor next to her bed on a crash pad, her legs were out in front of her. The note indicates that the resident did not use the call bell for assistance, and that the resident was very confused with altered mental status. The resident was assisted back into low bed with crash pads on floor at bedside. No injuries to the resident were noted for this fall. An event note dated February 2, 2025 at 2:33 PM revealed that the resident was found lying on her left side on the floor near her restroom. The resident had self-ambulated to her restroom with a walker and had non-slip socks on. The resident did not use her call light. Resident's eyes were open but did not respond when asked questions. No visible injuries were noted during that time. 911 was contacted and the resident was sent to the hospital. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note dated February 2, 2025 at 5:23 PM indicated that the resident went to the hospital and that the resident had sustained a rib fracture to 4 and 5. The resident was transported back to the facility and was alert and responsive. Per the Director of Nursing (DON) the resident would be on 15-minute checks. Review of the order summary revealed an active physician's order dated February 2, 2025 to check the resident every 15 minutes. No evidence of any other orders related to fall interventions were identified. A physician/physician's assistant/nurse practitioner note dated February 3, 2025 at 1:58 PM revealed that the resident was sent to the hospital for evaluation and had sustained left 4th and 5th rib fractures laterally, non-displaced, after resident fell in facility on February 2, 2025. An event note dated February 8, 2025 at 11:50 PM revealed that a crash was heard at the nurse's station and the resident was found lying on her left side. Blood was noticed to be on the floor, and the resident had a large laceration to the left elbow and a small hairline cut to the left orbital region. The note revealed that the resident was trying to hold onto the sink but just couldn't make it. Resident appeared to have altered mental status and was sent to the hospital for evaluation. A health status note dated February 9, 2025 at 2:25 AM indicated that the facility had spoken with the hospital and indicated that the resident sustained a new T1 compression fracture. An event note dated February 9, 2025 at 5:01 PM revealed that the resident was observed to be sitting on the floor in front of the nurse's station wearing a gown, brief, and non-skid socks. The resident's wheelchair was behind the nurse's station with the brakes engaged. The note indicated that the resident wanted to go back to bed but the wheels were locked so she tried scooting herself back to her room. The note also indicated that the resident stated she hit the back of her head and was then sent to the hospital for evaluation. An event note dated February 9, 2025 at 5:32 PM indicated that resident had returned to the facility and per the hospital, the resident sustained another rib fracture. An observation was conducted on March 5, 2025 at 11:55 AM of resident #18. The resident was laying in bed, with the bed low, and nonskid socks on both feet. During this observation, the surveyor attempted to interview the resident about the falls, the resident said she slipped but could not provide any other details about any of the fall incidents. The resident also stated that she does use her call light. An interview was conducted on March 5, 2025 at 11:38 AM with Certified Nursing Assistant (CNA/Staff #49) who stated that they are informed of resident's needs by either the nurses or other CNAs. She stated that she would be notified of fall interventions for residents by either the nurses or CNAs informing her, or on the fall packet that is done after a resident has a fall. The CNA stated that the fall interventions in place for resident #18 included having a fall matt on both sides of the bed and performing hourly checks. (continued on next page)

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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	An interview was conducted on March 5, 2025 at 11:42 AM with Licensed Practical Nurse (LPN/Staff #61) who stated that residents are assessed for falls upon admission, every three months, and as needed. The LPN stated that he is informed of what interventions are in place for residents by either the care plan, progress notes, or by report from other nurses. During the interview, the LPN reviewed resident's #18 clinical record and stated that the fall interventions for this resident included an active order for 15-minute checks and the resident being on the restorative program. An interview was conducted on March 5, 2025 at 1:40 PM with Certified Nursing Assistant (CNA/ Staff #47) who stated that he was not aware of any 15-minute checks that had been done for resident #18. The CNA also stated that it would be documented on the 15-minute check form and there was not one for this resident. In another interview with the LPN (staff #61) on March 5, 2025 at 1:58 PM, he stated that anyone could complete the 15-minute checks for the resident. He also stated that the risk of not completing the 15-minute checks could put the resident in danger for additional falls and injuries. An interview was conducted on March 5, 2025 at 1:24 PM with the health information management director (staff #11) who stated the CNAs or nurses fill out the 15-minute check forms when they complete the checks. She stated that the forms are collected from the nurse's station daily, but she did not have a 15- minute check form for resident #18. She further stated that it must be at the nurse's station #2 in her health information management box to be picked up. On March 5, 2025 at 1:35 PM staff #11 went to the nurse's station with the surveyor and observed that the health information management box was empty. Staff #11 stated that she could not find a 15-minute check form for resident #18. An interview was conducted on March 5, 2025 at 1:08 PM with the Director of Nursing (DON/Staff #39) who stated the process after a resident falls includes to meet with the DON, document the incident on the risk management form, and talk about what interventions are in place and what new interventions are needed. The DON also stated that the care plan should be updated at the same time the risk management form is completed. Once it is discussed then it would go into the nursing orders. Another interview was conducted on March 5, 2025 at 2:09 PM with the Director of Nursing (DON/Staff #39) who stated that the purpose of the 15-minute checks for the resident would be to help prevent further falls. The DON also stated that the risk of not completing the 15-minute checks of the resident could be further falls and injury. Review of the facility policy, Fall Management, reviewed September 25, 2024, indicated that the facility will assess the resident upon admission, quarterly, with change in condition, and with any fall event or fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. The policy also indicated that each resident will receive adequate supervision and assistance devices to prevent accidents. The policy revealed that the interdisciplinary team will review and revise the care plan upon a fall event and as needed thereafter.