STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035141	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health Care Center	1300 South Street Globe, AZ 85501

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47910 Based on documentation, staff interviews, and the facility policy and procedures, the facility failed to ensure one resident (#5) was provided with adequate supervision to prevent a fall. The deficient practice could result in residents being harmed physically and psychologically. Findings include: Resident #5 was admitted to the facility on [DATE], with diagnoses that included, difficulty in walking, not elsewhere classified, other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain, other osteoporosis without current pathological fracture, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. The assessment revealed no indicator for mood or behaviors, frequent incontinence for bowel and bladder and non-Alzheimer's dementia. Further review of the MDS assessment revealed resident #5 had one fall since admission or prior assessment resulting in a major injury. A care plan dated February 7, 2025, revealed a focus for activities of daily living (ADL) assistance and therapy service, a self-care performance deficit related to impaired balance, limited mobility related to weakness, and at risk for falls, the resident has impaired cognitive ability /impaired thought processes related to BIMS score 09/15, resident has had an actual fall. Interventions included to assist with (ADLs) as needed and to have call light within reach, requires assistance by staff to move between surfaces for transfers, requires assistance by staff for toileting, administer medications as ordered, Therapy screen sent, added non-slip socks, or encourage resident to have shoes on when transferring or walking. A Care Management Note dated April 16, 2025 revealed resident #5 found sitting on the bathroom floor on his buttock facing the toilet. The resident reported to staff he was trying to go to the bathroom, and slid to the ground off the wheelchair. resident reported not hitting his head, no redness or bruising present. It was noted the resident's weakness has increased. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Management Note dated April 16, 2025 revealed resident #5 was found in the bathroom sitting on the floor in front of his wheelchair facing the toilet. The note reports the resident was taking his socks off and was not wearing non-slip socks. A Care Management Note dated April 17, 2025 revealed housekeeping informed staff that resident had fallen on his head and needed help. Staff went to resident #5 room finding the resident on hands and knees with the crown of his head on the floor. Resident #5 was observed rocking back and forth, saying I can't move my legs. Resident's wheelchair was behind him and was in the doorway of his room when found. A Note Text dated April 18, 2025 revealed a falls review for April 16, 2025. Resident stated to staff that his socks were slippery and sat down on his buttocks. New intervention of encouraging patient to wear non-slip socks have shoes on when transferring or ambulating. A Note Text dated April 24, 2025 revealed Pressure reducing mattress and cushion to wheelchair in place. New Roho placed in chair this week as old cushion appeared wearing out (3/18/25). Encouraging frequent repositioning. Review of the physician's orders dated April 25, 2025 revealed a Stat upright Magnetic Resonance Imaging (MRI) of thoracic spine without contrast. Diagnosis back pain with T7 and T8 compression fractures on computerized tomography scan (CT). Review of the fall risk assessment outcomes revealed fall risk scores ranging from 18-8 dated July 23, 2023 through March 1, 2025 with the last admission assessment completed April 17, 2025 with score of 16. Review of emergency department evaluation dated April 17, 2025 revealed resident #5 presented to the emergency department with chief complaint of fall injury. Resident reported having some mid back pain. Evaluation documents fall resulted after resident had fallen asleep in chair and fell out of it. The exam of the back and pelvis revealed tenderness to palpitation of the T-spine midline in the area of the T-7-T-10 with no traumatic step-offs. Findings of the of the thoracic spine CT revealed increasing T-7 compression fracture now moderate to severe with marked surrounding soft tissue swelling. Findings also noted interval development of some mild superior endplate fracture of the T-8 adjacent vertebral body with marked loss of disc space between T-7 and T-8 with associated soft tissue swelling noted in this region. Further review of the evaluation of the CT imaging revealed the resident does have what appears to be a new mild T-8 endplate compression fracture with no retropulsion. Review of a consultation note dated April 21, 2025 revealed the following notation He has been complaining of back pain. He has had an evaluation which has included imaging studies which have revealed osteoporosis and fractures of the T spine at T7-T8. He is felt to have a combination of potential etiologies. One of the Vertebral Fractures is related to osteoporosis and the other due to osteoporosis and possible aggravation from slipping out of his wheelchair and landing on his buttocks. He has been treated with differing medications with some improvement. It is hoped that he can get into a pain specialist that offers vertebroplasty. This is in the works that is to say it has been ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation dated April 22, 2025, revealed per the documentation resident #5 had complained of back pain April 7, 2025 that was not relieved with medication. Results of the x-rays revealed no acute distress. The provider ordered a CT on April 10, 2025 with results of a compression T-7 mild to moderate fracture of indeterminate age. Resident had a fall on April 16, 2025 in the bathroom trying to go by himself without calling for assist and fell from his wheelchair. On April 17, 2025 the report states the resident sustained another fall when he fell forward and slid out of his wheelchair. The report states the resident sleeps in his wheelchair. The facility determined through their interviews with the resident, staff and family no mention of mishandling by anyone at the facility. An interview was conducted May 1, 2025 at 1:03 p.m. with resident #5. Observations made on entering the resident's room. Call light was on at 12:59, staff responded at 1:02p.m. resident's bed was unmade with no bedding. Resident was observed with non-skid sock with his shoes on. Resident reported that he had fallen in the facility twice. resident reported he had fallen off the toilet and had hurt his back. Resident reported he had called for help by pushing my button before attempting to change his underwear. Resident #5 stated they took too long and didn't come to help me. The resident stated this has happened in the past stating staff take a long time to come and help me-sometimes one hour or more and I can't wait that long. An interview was conducted May 1, 2025 at 1:06 p.m. with Registered Nurse (RN/Staff #46). She stated she is the residents nurse and is aware of his care. Staff #55 stated resident #5 has a wound on his coccyx, complains of back pain is continent of bowel and bladder and a moderate assist of one. She stated residents are assessed for falls if they have fallen before, are weak and by how alert they are. She stated resident #5 is a fall risk and has had two falls, once on April 17, 2025 and April 18, 2025. Staff #46 stated the first fall is a result of not cooperating with using the call light, had no shoes on and had slid from the wheelchair to the floor in the bathroom. She stated the second fall happened when the resident had fallen asleep in his wheelchair and fell forward out of the wheelchair and was found by housekeeping. She stated when she was notified by housekeeping she went to the room and found the resident on his hands and knees stating he could not get up. Staff #46 stated she was assisted by a CNA with a gait belt to lift back into the wheelchair. Staff #46 stated the resident had not injuries with the fall on April 17, 2025, but did complain of increased back pain and head pain due to hitting his head from the second fall. Staff #46 stated the provider was notified, vital signs, neuro checks and was sent to the emergency room . Staff #46 stated new interventions were placed after the first fall that included frequent checks, use of the call light and encourage to sleep in his bed. After the second fall interventions included re-education with the family and resident regarding reinforce interventions with their father. Staff #46 stated staff have increased founding, frequent reminders to use the call light and reached out to the Director of Nursing (DON/ Staff # 25) and the Assistant Director of Nursing (ADON/Staff # 15) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted May 1, 2025 at 1:29 p.m. with certified nursing assistant (CAN/Staff #55). Stated she is familiar with the resident's care and before his back issues was independent with his ADL's, but is now encouraged to use the call light and is now a one person assist with dressing and transfers to the toilet. Staff #55 stated she informed what fall interventions are needed for the residents from report from the nurse or the resident will wear a yellow arm band indicating they are a fall risk. There was no yellow arm band observed on the resident. Staff #55 stated she did not know why the resident did not have one. Staff #55 stated the resident is now a fall risk, stating she was not aware if the resident was a fall risk before his falls. Staff #55 stated she was unaware if resident #5 had sustained any injuries from his fall, but does have a pressure ulcer on his bottom and that his back was hurting. Staff #55 stated interventions in place prior to the falls were the use of non-skid socks and making sure call light in reach. She stated she was unaware of any new interventions post falls for resident #55. She stated the resident will refuse to use his call light and had an accident while in his wheelchair and was sitting in his feces, but did not know how long the resident had sat there since he did not call. An interview was conducted May 1, 2025 at 1:45 p.m. with Director of Nursing (DON/Staff #25) The DON stated prior to the fall resident #5 was set-up/independent- pull-up clothing and working with Restorative Nursing Assistant (RNA) 3xweek, post fall- off RNA, due to requiring requiring more of an extensive assist. She stated he is able to bear part of his weight, but does require assist with dressing and toileting. The DON stated staff are informed of a resident change of condition or level of care needed through report from shift to shift, the Kardex, education and continuity of care due to more changes to resident care and for new admissions and discharges. The DON stated residents are assessed for fall risk from a fall risk score and any changes mentally and physically, dementia or medical. She stated the resident was not a fall risk prior to his first fall. She stated the resident had fallen on April, 16 and April 17, 2025. She stated on April 16, 2025 that's when he went to the bathroom with socks on, his feet slipped and he sat down in the bathroom. She stated he was complaining of pain prior to the fall and had received the CT and X-ray prior to the first fall. The DON stated interventions in place prior to the first fall, were if he needed assist he would let us know and call light in reach. She stated interventions put into place after the first fall was a discussion of having regular socks and using non- skid socks. The facility implemented no skid socks after the second fall on April 17, 2025, conversation with staff and resident who would let us know to lay down him in the bed when he gets tired. She stated the resident has been agreeable has been agreeable to the interventions. Staff #25 stated it is her expectations that staff are informed of the resident's care plan, interventions and of any change of condition, that they ask their nurse, check the Kardex, or ask if they do not know. Review of the facility policy titled incident and Reportable Event Management The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction). (continued on next page)

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