STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055077	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Cove Post Acute	1730 Grand Ave Long Beach, CA 90804

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of seven sampled residents (Resident 1), who had an unwitnessed fall on 1/11/2025 with injuries, was provided appropriate care by the nursing staff. The facility failed to: 1. Ensure Resident 1 ' s physician was notified following Resident 1 ' s unwitnessed fall to obtain instructions for care and monitoring. 2. Ensure Resident 1 ' s Responsible Party (RP 1) was notified following Resident 1 ' s unwitnessed fall and subsequent injuries. 3. Ensure Resident 1 was assessed, monitored with documentation of Resident 1 ' s incident, and continued health status following his unwitnessed fall in order to update the physician of the resident status. 4. Ensure Resident 1 ' s incident and care were endorsed to the oncoming shift (7 a.m. - 3 p.m.) following his unwitnessed fall and injuries on 1/11/2025 during the 11 p.m. - 7 a.m. shift. This deficient practice resulted in a delay in Resident 1 ' s care following his unwitnessed fall with injuries on 1/11/20225, due to Licensed Vocational Nurse 2 ' s (LVN 2) failure to assess and monitor the resident, to document and report that Resident 1 had an unwitnessed fall. Resident 1 was subsequently transferred to an General Acute Care Hospital (GACH) on 1/13/2025, were he was assessed with multiple bruises in different healing stages to both his arms, swelling to the right foot, skin abrasion (a skin injury when the skin rubs off) with bruising and coagulated blood (a process that prevents excessive bleeding when a blood vessel is injured) to this right shoulder, the right bicep (a large muscle in the upper arm), right elbow and right knee. This deficient practice had the potential for serious injuries to be unknown by the resident ' s physician resulting in possible death. Findings: (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 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including atrial fibrillation ([Afib] a heart condition that causes an irregular heartbeat), cirrhosis of the liver (a type of liver damage where the healthy cells are replaced by scar tissue and the liver is not able to perform its vital functions for the body to function normally), right lung malignant neoplasm (a form of cancer that spreads into or invades nearby tissues) and pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 12/30/2024, the MDS indicated Resident 1 had periods of disorientation and was not able to make consistent and reasonable decisions and required a two-person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and was incontinent (loss of control) of bladder and bowel functions. During a review of Resident 1 ' s History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 1 was able to make his needs known but could not make medical decisions. During a review of Resident 1 ' s Order Summary Report (Physician ' s orders), the Order Summary Report indicated Resident 1 had the following orders: 1. On 11/7/2024 - Apixaban (a medication used to treat blood clots and prevent stroke with side effects of bleeding) 5.0 milligrams ([mg] a metric unit of measurement, used for medication dosage and/or amount) one tablet two times a day for Afib. 2. On 11/7/2024 - Aspirin (a medication used as to provide relief from pain and swelling and prevention of blood clots in the body with side effects of bleeding) 81 mg chewable one tablet daily for cerebrovascular accident prophylaxis (stroke prevention). During a review of Resident 1 ' s Care Plan related to the potential/actual impairment to skin integrity due to fragile skin, incontinence and limited mobility, dated 11/2/2023, the Care Plan indicated Resident 1 was to have no complications related to skin injury with interventions including following the facility protocols for treatment of injury and to monitor/document location, size and treatment of skin injury and report abnormalities to the primary care physician. During a review of Resident 1 ' s Care Plan on anticoagulant (drugs used to reduce the body ' s ability to form blood clots such as apixaban)/anti platelet (drugs such as aspirin which stop the blood cells from sticking together to form a clot) therapy related to Afib, and at risk for bleeding dated 6/14/2024. The goal of the Care Plan was for Resident 1 to be free from discomfort or adverse reactions to the anticoagulant ' use with interventions including inspecting Resident 1 ' s skin and report abnormalities to the nurse. During a review of Resident 1 ' s SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) and Change of Condition (COC) Charting and Skilled Documentation dated 1/11/2025 and timed at 8:10 a.m. , the SBAR and COC indicated Resident 1 was found with skin tears to the following areas of his body: (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	1. Right elbow 0.5 centimeters ([cm] metric unit of measurement, used for medication dosage and/or amount) by 0.5 cm. 2. Right thigh 1.0 cm by 1.0 cm. 3. Left lower leg 0.5 cm by 0.5 cm. 4. Right shoulder 0.5 cm by 0.5 cm. During a review of Resident 1 ' s Health Status Note dated 1/11/2025 and timed at 8:10 a.m., the Health Status Note indicated Resident 1 was observed with skin tears on his right shoulder measuring 0.5 by 0.5 cm, his right elbow measuring 0.5 by 0.5 cm, right leg/thigh measuring 1 cm by 1 cm, and his left below the knee measuring 0.5 cm by 0.5 cm. The Health Status Noted indicated Resident 1 reported the towel used by the certified nursing assistant (CNA 2) to clean him during the night shift was rough and caused his bleeding. During a review of Resident 1 ' s SBAR dated 1/13/2025 and timed at 12:13 p.m., the SBAR indicated Resident 1 had a fall incident and on 1/13/2025 the primary care physician recommended Resident 1 be sent to a GACH for a computerized tomography scan ([CT] a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce images of the inside of the body) of the head. During a review of Resident 1 ' s Health Status Note dated 1/13/2025 and timed at 12:13 p.m., the Health Status Note indicated Resident 1 had an alleged fall on 1/11/20205 at 5 a.m., based in a written statement by the Certified Nursing Assistant (CNA 2) assigned to care for Resident 1 on that shift (11 p.m. - 7 a.m.). The Health Status Note indicated Resident 1 sustained multiple discolorations and skin tears to his right shoulder measuring 0.5 by 0.5 cm, his right elbow measuring 0.5 by 0.5 cm, his right leg/thigh measuring 1 cm by 1 cm, and his left below the knee measuring 0.5 cm by 0.5 cm. During a review of Resident 1 ' s Order Summary Report date 1/13/2025, the Order Summary Report indicated to transfer Resident 1 to a GACH after an alleged unwitnessed fall. During a review of GACH ' s Emergency Department (ED) Documentation dated 1/14/2025 and timed at 4:12 a.m., the ED Documentation indicated Resident 1 presented to the GACH lethargic (a state of being drowsy and dull, listless, and unenergetic, indifferent and lazy, sluggish and inactive), with multiple bruises in different healing stages to both his arms, swelling to the right foot, skin abrasion with bruising and coagulated blood to the right shoulder, the right bicep, right elbow and right knee after an unwitnessed fall. (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 0580 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/13/2025 at 3:26 p.m., Resident 1 ' s RP 1 stated on 1/11/2025 at 11 a.m., he visited Resident 1 at the facility and was told by LVN 3 that Resident 1 was bleeding from multiple skin tears on his body. RP 1 stated LVN 3 did not know how Resident 1 sustained the skin tears and she did not receive a report from the nurses on 11 p.m. to 7 a.m. shift that Resident 1 had a COC. RP 1 stated Resident 1 told him and LVN 3 that the towel used on him was hard and rough and caused burning to his skin. RP 1 stated on 1/13/2025 at 11 a.m., he visited Resident 1 again and was told Resident 1 had an alleged fall on 1/11/2025 at 5 a.m., and he (Resident 1) would be transferred to a GACH for further evaluation and tests. RP 1 stated he was not informed by staff of Resident 1 ' s injury or fall that occurred on 1/11/2025 at 5 a.m., until he arrived at the facility (1/11/2025 at 11 a.m.). During an interview on 1/14/2025 at 11:10 p.m., Certified Nursing Assistant 2 (CNA 2) stated on 1/10/2025 during the 11 p.m. to 7 a.m. shift, she noticed Resident 1 was moving a lot in bed at the beginning of the shift and she informed LVN 2 about Resident 1 ' s restlessness. CNA 2 stated Resident 1 ' s legs were dangling off the side of the bed, and she had to reposition him several times. CNA 2 stated around 5 a.m., on 1/11/2024, she was passing by Resident 1 ' s room and saw Resident 1 lying on floor face up by the right side of his bed. CNA 2 stated Resident 1 had a bowel movement on the floor, and she informed LVN 2 of Resident 1 ' s situation. CNA 2 stated she and LVN 2 placed Resident 1 back in bed, she cleaned him up but and did not notice any wounds on Resident 1 but stated she did see a minimal amount of blood on the floor. CNA 2 stated LVN 2 took over Resident 1 ' s care after she (CNA 2) was finished cleaning Resident 1 up and since LVN 2 was aware of Resident 1 ' s incident, she left at the end of her shift and did not inform the incoming nurses of Resident 1 ' s fall incident because she thought LVN 2 would report what happened. During a telephone interview on 1/15/2025 at 11:55 a.m., LVN 2 stated on 1/10/2025 during the early part of the 11 p.m. to 7 a.m. shift she was informed by CNA 2 that Resident 1 was restless in bed. LVN 2 stated when she checked on Resident 1, he was pulling off his oxygen tubing. LVN 2 stated she assisted Resident 1 to reposition in bed and reminded him to keep his oxygen tubing in place. LVN 2 stated at 5 a.m. on 1/11/2025, she was informed by CNA 2 that Resident 1 was lying on the floor on the right side of his bed. LVN 2 stated Resident 1 did not look like he was in distress or pain, therefore she did not check his vital signs ([v/s] the measurements of the body ' s essential functions, such as temperature, breathing rate, pulse, blood pressure and level of pain) nor did she do a full assessment including a neuro check on Resident 1. LVN 2 stated she assessed Resident 1 ' s skin after CNA 2 completed Resident 1 ' s incontinence care and stated she observed a small amount of bleeding to Resident 1 ' s right upper arm and left it open to air, because the area looked like an old wound that possibly reopened after the fall. LVN 2 stated she did not feel like Resident 1 had fallen since Resident 1 was always on a low bed, so she did not call Resident 1 ' s physician or RP 1 regarding the incident, she did not document the incident or Resident 1 ' s status in his medical record and she did not endorse anything to the oncoming shift (7 a.m. -3 p.m.) because she did not feel like Resident 1 had a COC. LVN 2 stated she should have called Resident 1 ' s physician and RP 1 so the physician could decide on what interventions the resident needed, and transfer Resident 1 to the GACH for further care and evaluation as necessary. LVN 2 stated documenting in the resident ' s medical record during a COC was important to ensure the resident ' s health progress and assessments were recorded and the resident ' s condition was communicated to the healthcare team. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 1/15/2025 at 12:32 p.m., LVN 3 stated during her initial resident rounds on 1/11/2025 at 8 a.m., and upon assessment of Resident 1, she noted Resident 1 had multiple skin tears on his body. LVN 3 stated she was not informed by the previous shift of Resident 1 ' s skin tears or possible COC and there was no documentation in Resident 1 ' s medical record to reflect that anything had occurred during the previous shift. LVN 3 stated on 1/13/2024 during the 7 a.m. to 3 p.m. shift, she was informed that Resident 1 had an alleged fall on 1/11/2025 at 5 a.m. LVN 3 stated Resident 1 was on medications with side effects of bleeding, and he should have been assessed at the time of the fall with documentation in his medical record as well as a report to the oncoming nurses, Resident 1 ' s physician and his RP. During an interview on 1/14/2025 at 10:10 p.m., the Director of Nursing (DON) stated Resident 1 ' s alleged fall was discovered on 1/13/2025 after the facility investigated Resident 1 ' s skin injuries. The DON stated the nurses are expected to assess and monitor any resident when there is a COC to determine the residents ' condition and progress in order to identify continued changes. The DON stated the licensed nursing staff should have informed Resident 1 ' s physician, to obtain instructions for care to prevent a delay in treatment and any complications. During a telephone interview on 1/15/2025 at 5:42 p.m., Resident 1 ' s Physician stated she was made aware of Resident 1 ' s multiple skin tears and alleged fall on 1/13/2025 and ordered that Resident 1 be transferred to a GACH for further evaluation. Resident 1 ' s physician stated the facility nursing staff should have called her immediately after Resident 1 was found on the floor so she could have ordered a Stat (immediate) Xray to determine if Resident 1 was injured and to instruct the nursing staff to monitor Resident 1 because he was at risk for bleeding due to medications that he was taking. Resident 1 ' s physician stated Resident 1 should have been assessed including a neuro check to identify and keep track of the resident ' s progress and response to treatment. During a review of the facility ' s Policy and Procedure (P/P) titled, Change of Condition Notification revised 4/1/2015, the P/P indicated the resident ' s change of condition is defined when any sudden and marked change in the residents ' condition which is manifested by signs and symptoms different than usual denote a problem, complication or permanent change in the residents ' status and require medical assessment, coordination and consultation with the attending physician and a change in the treatment plan. The P/P indicated the licensed nurse will notify the resident ' s attending physician and legal representative or an appropriate family member when there is an: a. Incident/ accident involving the resident, b. An accident involving the resident which results in an injury and has the potential for requiring physician intervention. c. Significant change in the residents ' physical, mental or psychosocial status such as deterioration of health, mental or psychosocial status, life threatening conditions and/or clinical complications. The Licensed Nurse will notify the family/surrogate decision makers of any changes in the residents ' condition as soon as possible. The Licensed Nurse will document the time the attending physician was notified and the method by which physician was contacted, the response time, and whether or not orders were received, the time the family/responsible person was notified

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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	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** 45537 Based on interview and record review, the facility failed to ensure an injury of unknown origin for one of seven sampled residents (Resident 1) was reported to the California Department of Public Health (CDPH) when Resident 1 sustained multiple skin tears on his body. This deficient practice resulted in the inability of the CDPH to investigate Resident 1's injuries in a timely manner and had the potential for facts related Resident 1's injuries to be forgotten by staff. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including atrial fibrillation ([Afib] a heart condition that causes an irregular heartbeat), cirrhosis of the liver (a type of liver damage where the healthy cells are replaced by scar tissue and the liver is not able to perform its vital functions for the body to function normally), right lung malignant neoplasm (a form of cancer that spreads into or invades nearby tissues) and pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 12/30/2024, the MDS indicated Resident 1 had periods of disorientation and was not able to make consistent and reasonable decisions, he required a two-person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), and was incontinent (loss of control) of bladder and bowel functions. During a review of Resident 1's History and Physical (H&P) dated 11/4/2024, the H&P indicated Resident 1 was able to make his needs known but could not make medical decisions. During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) and Change of Condition (COC) Charting and Skilled Documentation dated 1/11/2025 and timed at 8:10 a.m. , the SBAR and COC indicated Resident 1 was found with skin tears to the following areas of his body: 1. Right elbow 0.5 centimeters ([cm] metric unit of measurement, used for medication dosage and/or amount) by 0.5 cm 2. Right thigh 1 cm by 1 cm 3. Left lower leg 0.5 cm by 0.5 cm 4. Right shoulder 0.5 cm by 0.5 cm. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Health Status Note dated 1/11/2025 and timed at 8:10 a.m., the Health Status Note indicated Resident 1 was observed with skin tears on his right shoulder measuring 0.5 by 0.5 cm, his right elbow measuring 0.5 by 0.5 cm, right leg/thigh measuring 1 cm by 1 cm, and his left below the knee measuring 0.5 cm by 0.5 cm. The Health Status Noted indicated Resident 1 reported the towel used by the certified nursing assistant (CNA 2) to clean him during the night shift was rough and caused his bleeding. During a telephone interview on 1/13/2025 at 3:26 p.m., Resident 1's Responsible Party (RP 1) stated on 1/11/2025 at 11 a.m., he visited Resident 1 at the facility and was told by Licensed Vocational Nurse 3 (LVN 3) that Resident 1 was bleeding from multiple skin tears on his body. RP 1 stated LVN 3 did not know how Resident 1 sustained the skin tears and she did not receive a report from the nurses on 11 p.m. to 7 a.m. shift that Resident 1 had a COC. RP 1 stated Resident 1 told him and LVN 3 that the towel used on him was hard and rough and caused burning to his skin. During a telephone interview on 1/15/2025 at 12:32 p.m., LVN 3 stated on 1/11/2025 at 8 a.m., she observed that Resident 1 had multiple skin tears on his body. LVN 3 stated she was not informed about Resident 1's skin tears by the previous shift (11 p.m. to 7 a.m.) and there was no documentation regarding Resident 1's COC in Resident 1's medical record. LVN 3 stated Resident 1 told her it could have been the towel used by the previous shift that caused him (Resident 1) to bleed. LVN 3 stated she should have reported Resident 1's injury the Director of Nursing Services (DON) and/or the Administrator (ADM During a telephone interview on 1/15/2025 at 2:25 p.m., Registered Nurse Supervisor 1 (RNS 1) stated skin tears, discoloration and hematomas (a collection of blood outside of a blood vessel caused by a broken blood vessel) without a known cause should be reported to the California Department of Public Health (CDPH) within 24 hours and/or sooner. RNS 1 stated failure to report the unusual occurrence and unknown injuries to CDPH could potentially subject the resident(s) to repeated mistreatment which could cause the residents to be unsafe. During an interview on 1/14/2025 at 10:10 p.m., the Director of Nursing (DON) stated she was not informed of Resident 1's COC that occurred on 1/11/2025, she found out about it on 1/13/205 when she returned to work and was looking through the COC's that had occurred over the weekend. The DON stated Resident 1's COC indicated he had multiple skin tears and she (DON) thought Resident 1's injuries were questionable/unusual and did not believe they happened because of a rough towel. The DON stated she did not report Resident 1's injuries to the CDPH because the licensed nurses reported the injuries were caused by the staff using a rough towel. The DON stated she should have reported Resident 1's injuries to the CDPH within 24 hours. During an interview on 1/15/2025 at 3:37 p.m., the Administrator (ADM) stated injuries of unknown origin and unusual occurrences should have been reported to the CDPH especially when the cause and extent of Resident 1's injuries were questionable. During a review of the facility's Policy and Procedure (P/P) titled, Abuse Prevention and Management revised 5/30/2024, the P/P indicated the facility will promptly report to the appropriate government agencies concerns of abuse, mistreatment, neglect and injuries of unknown origin as required by law.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure one of seven sampled residents (Resident 4), who had a history of falling was provided a one on one sitter (a person who provides constant observation and assistance to a resident at risk for harm), per the physician's order. This deficient practice resulted in Resident 4 not being closely supervised at all times placing Resident 4 at risk for continued falls and subsequent injuries. Findings: During a review of Resident 4's Admission Record (Face Sheet), the Face Sheet indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a change in how the brain works due to an underlying condition that causes confusion, memory loss and loss of consciousness), Parkinsonism (a clinical syndrome characterized by tremors, bradykinesia [slow movement], rigidity [a condition where muscles feel stiff and resistant to movement], postural instability and epilepsy (a brain disorder in which a person has repeated seizures [uncontrolled movement]) During a review Resident 4's Minimum Data Set ([MDS] a resident assessment tool) dated 12/30/2024, the MDS indicated Resident 4 was usually understood and able to understand others, she was able to make decisions that were consistent and reasonable, she required partial moderate assistance using a one person assist to complete her activities of daily living ([ADLS] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and was occasionally incontinent (loss of control) of bladder functions. During a review of Resident 4's History and Physical (H&P) dated 11/21/2024, the H&P indicated Resident 4 had a fluctuating (constantly changing) capacity to understand and make decisions. During a review of Resident 4's Fall Risk Evaluation dated 1/3/2025 and timed at 2:12 p.m., the Fall Risk Evaluation indicated Resident 4 had a score of 12 (a score of 10 and higher indicated a high risk for falls). The Fall Risk Evaluation indicated Resident 4 had three or more falls in the past three months, was chairbound (unable to walk and dependent on a wheelchair for mobility) and had intermittent (on and off/ bouts of) confusion. During a review of Resident 4's Progress Notes (Post Fall Evaluation) dated 1/5/2025 and timed at 2:26 p.m. , the Post Fall Evaluation Note indicated Resident 4 had an unwitnessed fall in her room when she reached for items that were on her bedside table. The Post Fall Evaluation indicated Resident 4 had an 8 out of 10 pain (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) to her right ear, and occipital (the back of the head) and frontal the front of the head) areas of her head. During a review of Resident 4's Order Summary Report (Physician's Order), dated 1/5/2025, the Physician's Order indicated to provide Resident 4 a one to one sitter for safety. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's Care Plan on Unwitnessed Falls dated 1/5/2024, the Care Plan indicated Resident 4 had an unwitnessed fall in her room (1/5/2025) and hit her right ear on the footboard of her bed and on the floor. The Care Plan's goal was for Resident 4 to have no ill effects after the fall with an intervention to provide and ensure Resident 1 had a one on one sitter for safety. During an observation and interview on 1/14/2025 at 7:44 p.m., Resident 4 was observed lying on the edge of her bed moving around attempting to reposition herself, there was no nursing staff observed in the room. During an observation on 1/14/2025 at 9:18 p.m., with Certified Nursing Assistant 1 (CNA 1) who was asked to come to Resident 4's room, Resident 4 was observed without a sitter present, lying on the edge of her bed attempting to reach the overhead light with her right hand. Resident 4 was unable to reach the overhead light despite several attempts because of tremors to her right arm. CNA 1 assisted Resident 4 to turn on the overhead light and informed Resident 4 to call for assistance. During an interview on 1/14/2025 at 9:30 p.m., CNA 1 stated Resident 4 was forgetful, needed constant reminders and close supervision/frequent checks because she would always go to the restroom by herself and use the toilet on her own. CNA 1 stated Resident 4 was unsteady and shuffled when she walked, and she would try to do many tasks that were beyond her capacity. CNA 1 stated Resident 4 should have a sitter but one was not always assigned to her and confirmed that there was no one assigned as her sitter today (1/14/2024). During an interview on 1/14/2025 at 9:37 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 4 had multiple falls in the past and had an order for a one on one sitter for safety. LVN 1 stated no one was assigned as Resident 4's one on one sitter today (1/14/2025). LVN 1 stated Resident 4 was forgetful, impatient, unsteady when walking due to tremors. She often tried to do tasks beyond her capacity and needed a sitter to consistently assist her with her care and ADLs. During an interview on 1/14/2025 at 10:01 p.m., Registered Nurse Supervisor 1 (RNS 1) stated Resident 4 was assessed as high risk for falls and Resident 4's physician ordered that Resident 4 have a one on one sitter following her fall on 1/5/2025. RNS 1 stated she informed the facility staff as well as the department heads of the order for Resident 4 to have a one on one sitter but no one was assigned to Resident 4 consistently. RNS 1 stated she was aware there was no sitter for Resident 4 today (1/14/2024) but stated, I only work here, don't make the decisions on staffing and I can't say anything about it. During an interview on 1/14/2025 at 10:10 p.m., the Director of Nursing (DON) stated she was not able to keep track of the fall risk residents and was not able to ensure staff was assigned to Resident 4 one on one. During a review of the facility's Policy and Procedure (P/P) titled, Fall Management Program dated 3/13/2021, the P/P indicated the facility will provide the residents a safe environment that minimizes complications associated with falls. The P/P indicated the Interdisciplinary Team of the facility shall meet and review the residents' fall risk interventions for appropriateness and effectiveness and shall update/revise the residents' care plans with the IDT's recommendations.