STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 - Minimal harm or potential for 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** 42123 Based on interview and record review, the facility failed to notify the Responsible Party (RP) for one of six sampled resident ' s (Resident 2) when Resident 2 ' s room was changed on 2/23/25 and he fell on [DATE]. This failure violated Resident 2 ' s rights when his RP was not informed of a change in care. Findings: During a concurrent observation and interview on 3/6/25 at 10:50 a.m. with Resident 2, Resident 2 sat up in his wheelchair, Certified Nursing Assistant (CNA) 1 was at bedside. CNA 1 stated she was assigned to provide Resident 2 with one-on-one supervision while the assigned CNA was at lunch. Family Member (FM) 3 walked into Resident 2 ' s room and asked Resident 2 why there was a CNA sitting with him. Resident 2 informed FM 3 he had multiple falls since his admission to the facility. FM 3 was upset and asked, why are they letting him fall? FM 3 stated he had not been notified Resident 2 had fallen, but FM 2 was his RP, and they may have notified her. Resident 2 stated FM 2 was his RP, and he was not sure if the facility had notified her about his falls. During a review of Resident 2 ' s Admission Record (AR), undated, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included fracture of left acetabulum (break in the hip socket), fracture of sacrum (bone located at the base of the spine), paraplegia (loss of movement and/or sensation, to some degree), muscle weakness, abnormalities of gait (manner of walking) and mobility (ability to move freely) and repeated falls. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 07 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 had a severe cognitive impairment. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25 at 10:50 a.m. with Minimum Data Set Coordinator (MDSC) 2, Resident 2 ' s AR, undated, was reviewed. MDSC 2 stated Resident 2 ' s sister (FM 2) was his RP. During a review of Resident 2 ' s Social Service Note, dated 2/21/25 at 12:13 p.m., the note indicated, . Talked with Resident ' s sister [name] regarding Resident ' s cognition, and she say that she will be happy to become the Resident ' s RP . MDSC 2 stated the documentation indicated Resident 2 ' s FM 2 was the assigned RP as of 2/21/25 and should have been notified of Resident 2 ' s room change on 2/23/25 and fall on 2/26/25. Resident 2 ' s Change in Condition Evaluation dated 2/26/25 indicated, . writer heard resident calling for help, upon entering room resident was found sitting on floor . Resident Representative Notification . Name of family/resident representative notified . [Resident 2 ' s name] . Date and time of family/resident representative notification . 2/26/25 . MDSC 2 stated any change in condition the RP had to be notified. During a telephone interview on 3/6/25 at 11:09 a.m. with FM 2, FM 2 stated she was Resident 2 ' s RP due to his impaired cognition. FM 2 stated she was not notified of Resident 2 ' s room change or fall. FM 2 stated she did not find out Resident 2 had changed rooms until another family member came to see the resident and he was in a different room. FM 2 stated she was upset because the facility did not provide a reason for the room change and moved Resident 2 into a room where he cannot safely use the grab bars in the restroom. FM 2 stated Resident 2 is paralyzed on his left side and when sitting on the toilet, the only grab bars within reach were to the left. FM 2 stated a family member asked a nurse to move Resident 2 into a room with grab bars on the right side so he could safely get off the toilet and was told they could not accommodate him. FM 2 stated she was also not notified he had a fall on 2/26/25 and was upset because it was not his first fall since admission. During a concurrent observation and interview on 3/6/25 at 1:30 p.m. with Resident 2, Resident 2 sat on his bed. Resident 2 ' s bathroom was observed, and the grab bars were noted to the left side if sitting on the toilet. A single grab bar was noted next to the doorway but a person sitting on the toilet would need to lean forward to reach it. Resident 2 stated he had to get off the toilet very carefully because he could not use the grab bars. Resident 2 stated he was not sure why they had moved him, but nobody told him the grab bars in the bathroom would not be within reach. Resident 2 stated in his previous room he was able to use his right arm to get on and off the toilet. During an interview on 3/6/25 with CNA 1, CNA 1 stated it was difficult to get Resident 2 off the toilet because he was unable to use the grab bar because his left side was paralyzed. During a concurrent interview and record review on 3/6/25 at 1:48 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was the nurse on duty when Resident 2 ' s room was changed on 2/23/25. LVN 3 reviewed Resident 2 ' s chart and was unable to locate documentation regarding Resident 2 ' s room change or RP notification. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25 at 2:03 p.m. with the Social Services Director (SSD) and Social Services Assistant (SSA), the SSD stated the normal process for room change was to complete a room change report. The SSD stated social services were not at facility over the weekend and they were never notified of Resident 2 ' s room change. The facility ' s policy and procedure (P&P) titled Room Change/Roommate Assignment, dated 2/2023 was reviewed. The P&P indicated, . Resident room or roommate assignments may change if the facility deems it necessary . Prior to changing a room or roommate assignment all parties involved in the change/assignment . are given at least advance notice of such change . The SSD stated the P&P indicated Resident 2 ' s RP should have been notified prior to the room change. The SSA reviewed Resident 2 ' s electronic medical record and was unable to locate any documentation of his room change except the census had reflected a move on 2/23/25. The SSD stated there should have been documentation including RP notification before his room was changed. The SSD stated the P&P was not followed. The SSD stated she spoke to Resident 2 and FM 2 about FM 2 becoming his RP on 2/21/25 and they were both in agreement. During an interview on 3/6/25 at 3:02 p.m. with the Director of Nursing (DON), the DON stated she was new to the facility and was not aware of the facility ' s process for room change and RP notification. The DON stated it was important to check the room and make sure it was environmentally fitting for the resident. The DON declined to say if Resident 2 ' s flaccid (limp) left side made his bathroom unsafe for him. The DON stated Resident 2 ' s RP should have been notified of his fall and the room change. During review of the facility ' s policy and procedure (P&P) titled Change in a Resident ' s Condition or Status, dated 2/2021, the P&P indicated, . Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status . a nurse will notify the resident ' s representative when . the resident is involved in any accident or incident that results in an injury . there is a significant change in the resident ' s physical, mental, or psychosocial status . there is a need to change the resident ' s room assignment . it is necessary to transfer the resident to a hospital . The nurse will record in the resident ' s medical record information relative to changes .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 44899 Based on observation, interview, and record review, the facility failed to maintain a safe and comfortable environment for one of 13 sampled residents (Resident 9) when Resident 9 ' s hospital bed ' s footboard was loose and detached from the bedframe, and visible to passersby. This failure violated Residents 9 ' s rights to a comfortable and homelike environment that would respect the residents' dignity and well-being. Findings: During a review of Resident 9's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/7/25, the AR indicated, Resident 9 was admitted from an acute care hospital on 5/19/16 to the facility, with diagnoses that included Cerebrovascular Disease (stroke- bleeding inside the brain) affecting right side of the body, Congestive Heart Failure (CHF- weakness in the heart where fluid accumulates in the lungs), Generalized Muscle Weakness, and Hypertension (high blood pressure). During a review of Resident 9's Minimum Data Set (MDS-comprehensive, standardized assessment of residents' functional capabilities and health needs), dated 2/8/25, the MDS indicated, Resident 9 ' s BIMS (Brief Interview for Mental Status) score was 3 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact). During a concurrent observation and interview on 3/6/25 at 11:15 a.m., with Certified Nurse Assistant (CNA) 8, inside Resident 9's room, Resident 9 was observed lying in bed and asleep. CNA 8 stated Resident 9 ' s hospital bed ' s footboard was not properly attached to the bedframe, two out of four screws were loose and the bed was visible to passersby. CNA 8 stated the loose footboard was an on-going issue and she and other CNAs usually take care of it. During a concurrent interview and record review on 3/6/25, at 4:24 p.m., with the Assistant Director of Nursing (ADON), Resident 9's hospital bed ' s photo, dated 3/6/25 was reviewed. The ADON stated Resident 9's hospital bed ' s footboard was loose and it was an environmental hazard. The ADON stated she expected licensed nurses and CNAs to report any equipment issues to the maintenance department for immediate action. The ADON stated the maintenance department was responsible in repairing or replacing hospital beds. During a concurrent observation and interview on 3/6/25, at 4:25 p.m., with the Maintenance Director (MAIND), inside Resident 9's room, the MAIND stated Resident 9's hospital bed ' s footboard was not properly attached to the bedframe and requires immediate repair. The MAIND stated the loose footboard could cause injury to Resident 9. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25, at 4:29 p.m., with the MAIND, the facility ' s Maintenance Log, undated was reviewed. The Maintenance Log indicated, . Date . 9/4/24 . Nursing . Description . Resident bed does not go up . The MAIND stated, Resident 9's hospital bed ' s loose footboard was not reported or documented. The MAIND stated, he received calls from staff about equipment needing repairs but he doesn ' t check the Maintenance Log daily and he should. During an interview on 3/7/25, at 3:21 p.m., with the Director of Nursing (DON), the DON stated Resident 9 ' s hospital bed ' s loose footboard was an environmental hazard and not acceptable. The DON stated the bed should be repaired immediately. The DON stated, the facility should maintain a safe and home-like environment for all residents, including Resident 9. The DON stated she expected licensed nurses and CNAs to report any equipment issues to the maintenance department using the maintenance log and for the Maintenance Department to check the log daily and resolve any issues as soon as possible. During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated 10/24 was reviewed. The P&P indicated, . Residents are provided with a safe, clean, comfortable and homelike environment . During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated 10/24 was reviewed. The P&P indicated, . Residents are provided with a safe, clean, comfortable and homelike environment . During a review of the facility's document titled, Maintenance Manager, undated was reviewed. The document indicated, . Essential Duties and Responsibilities . Performing regular inspections of resident rooms for order safety and proper performance of equipment . Maintaining maintenance logs weekly, monthly, and quarterly as required .

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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** 44899 Based on interview and record review, the facility failed to report an unwitnessed fall with injury to the California Department of Public Health (CDPH- State survey agency) within the required time frame for one of ten sampled residents (Resident 2) when Resident 2 fell twice from his bed on 2/20/25, unwitnessed on both occasions. Resident 2 hit his head during a fall on 2/20/25 at 6:15 a.m. causing a skin tear to his left eyebrow and fell again on 2/20/25 at 10:35 p.m. hitting his head in the same area causing further trauma to the left eyebrow resulting in a laceration (cut or tear in the skin caused by blunt force). Resident 2 required transportation to the emergency room for sutures (threads used to close wounds) to repair the wound. This failure resulted in Resident 2's fall not investigated timely within the required time frame and had the potential to result in Resident 2's safety needs not met. Findings: During a review of Resident 2's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/3/25, the AR indicated Resident 1 was admitted to the facility from the acute care hospital on 2/2/25, with diagnoses that included Fracture of Left Acetabulum (break in the hip socket), Fracture of Sacrum (bone located at the base of the spine), Paraplegia (loss of movement and/or sensation, to some degree), Muscle Weakness, Abnormalities of Gait (manner of walking) and Mobility (ability to move freely) and Repeated Falls. During a review of Resident 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 07 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 had a severe cognitive impairment. During an observation on 3/3/25 at 12:18 p.m. in Resident 2's room, Resident 2 was observed sitting on the edge of his bed, watching TV, and with no staff present in the room. Resident was also observed with left sided weakness. (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 concurrent interview and record review on 3/5/25 at 10:12 a.m. with the Minimum Data Set Coordinator (MDSC) 1, Resident 2's Change in Condition Evaluation (CIC), dated 2/20/25 was reviewed. The CIC indicated, . Resident was on the floor sitting next to his bed. Upon assessment noted skin tear to Left eyebrow . Resident stated that he was just sitting on the side of the bed and fell asleep. He said he fell forward and hit his head on the bedside table when he fell on the floor . Effective Date 2/20/25 6:15 [a.m.] . Writer heard some noise in the [Resident 2 ' s room] during writer getting report from the PM [evening] nurse. Writer and PM nurse hurried over toward the noise. Resident was sitting on the floor right side of the bed. Upon assessment resident has laceration to left side of forehead noted, bleeding noted. Applied pressure to stop the bleeding. MD [Attending Physician] notified and received new orders noted and carried out . Resident stated that he was sitting on the side of the bed and fell forward and hit his head on the bedside table when he fell on the floor . Effective Date 2/20/25 22:35 [10:35 p.m.] . MDSC 1 stated there was no documented notification to CDPH. MDSC 1 stated, We can ' t avoid [Resident 2] from falling. He has medical diagnosis contributing to his falls and he has history of falls before coming to our facility. MDSC 1 stated she can ' t find any documentation stating CDPH was notified of the two unwitnessed fall with injury on 2/20/25. MDSC 1 stated the ADM and DON were responsible in determining reportable events to CDPH. During a concurrent interview and record review on 3/5/25 at 12:02 p.m. with the Director of Nursing (DON), Resident 2's Post-Fall Review dated 2/21/25 and 2/27/25 were reviewed. The Post-Fall Review indicated, . IDT met to review Resident ' s fall on 2/20/25 . He received a skin tear to his left eyebrow with some bleeding. Risk Factors: Resident has diagnoses of Abnormalities of Gait and Mobility, Repeated falls . Anxiety (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness), and Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Convulsions (an abnormal and involuntary shortening of the muscles) . Has BIMS of 7. Poor safety awareness . Signed [DON] . Signed Date 2/20/25 . Writer heard some noise in the [Resident 2 ' s room] during writer getting report from the PM nurse. Writer and PM nurse hurried over toward the noise. Resident was sitting on the floor right side of the bed. Upon assessment resident has laceration to left side of forehead noted, bleeding noted. Applied pressure to stop the bleeding. MD notified and received new orders noted and carried out . IDT met to review Resident ' s fall on 2/20/25 Risk factors: PARAPLEGIA . Repeated Falls . Muscle Weakness . Cognitive impairment, poor safety awareness . Recommendations: Floor mat to minimize the risk for injury . 5. Monitor for Laceration to left side of forehead for any CIC . Signed [ADON] . Signed Date 2/21/25 . The DON stated Resident 2 ' s two incidents of unwitnessed fall with injury on 2/20/25 were not reportable incident to CDPH. The DON stated Resident 2 was expected to fall due to his medical condition. The DON stated, We anticipated that he [Resident 2] will fall. Our interventions are geared towards minimizing injury related to unavoidable falls. The DON stated Resident 2 had another fall on 2/26/25 and he sustained an abrasion to right knee. During an interview on 3/6/25 at 4:03 p.m. with the Administrator (ADM), the ADM stated he and the DON determine if a fall was a reportable event or not. The ADM stated they follow the policy on reporting falls according to the timeline. The ADM was unaware of Resident 2 ' s four falls from 2/15/2 to 2/26/25 and was unable to gave a statement if the two unwitnessed falls with injury on 2/20/25 were reportable or not. (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 2 ' s document titled, Emergency Department (ED) Provider Notes, dated 2/21/25, the document indicated, . Chief Complaint . Patient Presents with Fall . Two ground level falls today at [Nursing Home Name] . Per EMS [Emergency Medical Staff], his first fall was this morning at 06:00 during which he slipped out of bed and struck his head on a table. Then at 23:30 he slipped out of his ben once again prompting visit to ED . Physical Exam . Face: Single 4 cm (centimeter- unit of measurement) hemostatic superficial laceration to the left eyebrow . Laceration involves the dermis and epidermis, no subcutaneous or muscle involvement . Lac [laceration] repaired in ED as in procedural note . During a review of the facility ' s document titled, Job Description: Administrator, undated, the document indicated, . The primary purpose of your job description is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provide to our residents at all times . During a review of the facility policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/22, the P&P indicated, . 1. If a resident abuse, neglect . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility . 6. Upon receiving any allegations of abuse, neglect, exploitation, . or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan was developed and implemented to meet the identified needs for two of six sampled residents (Residents 1 and 2) when: 1. Resident 1 was admitted to the facility with a history of falls, assessed as being a fall risk and a known behavior of not calling staff for assistance and the facility did not develop and implement effective care plan interventions including assistance and supervision to prevent falls. This failure resulted in Resident 1 ' s unwitnessed fall on 1/30/25, sustaining an intertrochanteric fracture (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis), pain, decreased mobility and required transportation to the emergency room and admission to the acute care hospital (ACH) for seven days. (cross reference F689) 2. Resident 2 was admitted to the facility with left sided paralysis, a history of falls and assessed as a fall risk with a behavior of sitting at the edge of the bed unsupervised and did not develop and implement effective care plan interventions to prevent falls. This failure resulted in Resident 2 falling four times, on 2/15/25, 2/20/25 at 6:15 a.m. and 2/20/25 at 10:35 p. m., and on 2/26/25. Resident 2 sustained a laceration above his left eyebrow during the fall on 2/20/25 at 10:35 p.m. which required transportation to the emergency room for sutures. (cross reference F689) Findings: During a concurrent observation and interview on 2/12/25 at 9:47 a.m. with Resident 1, Resident 1 was lying in bed, the bed was in the lowest position. Resident 1 had involuntary tremors of her arms and legs. Resident 1 stated she was in pain and pointed to her right hip. Resident 1 stated she had fallen in the bathroom and became tearful and visually upset. Resident 1 stated I just fell [on 1/30/25]. During a review of Resident 1 ' s ACH document titled Case Management Discharge Summary/Orders Report, dated 2/7/25, the note indicated, . admitted : 1/31/2025 . discharge date : 2/7/2025 . Slip and fall coming out of bathroom landing on her right hip . Admission Diagnoses: Intertrochanteric fracture . Procedures . Open Reduction Internal Fixation [surgical procedure that treats intertrochanteric hip fractures] Femur (Right) . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of T5-T6 vertebra (a break in the bones in your back that stack up to form your spine part of the vertebra [bones that make up the backbone] collapses), COPD (chronic obstructive pulmonary disease-chronic lung disease causing difficulty in breathing), Chronic respiratory failure (medical condition where the blood has low oxygen [colorless odorless gas essential to life] levels), Parkinsonism (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), abnormalities of gait (persons manner of walking) and mobility, history of falling and muscle weakness. During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 12 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had a moderate cognitive impairment. During an interview on 2/12/25 at 10:04 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to Resident 1. CNA 1 stated she had taken care of Resident 1 before her fall on 1/30/25. CNA 1 stated Resident 1 required supervision and touch assistance for balance and safety while ambulating to the bathroom before the fall. CNA 1 stated she would stay nearby when Resident 1 was in the bathroom because the resident was a high fall risk and was forgetful. CNA 1 stated Resident 1 would not remember to use the call light and wait for help to go back to bed. CNA 1 stated Resident 1 did not have any fall interventions in place prior to her fall. During an interview on 2/12/25 at 11:31 a.m. with CNA 2, CNA 2 stated she was familiar with Resident 1. CNA 2 stated Resident 1 would not consistently use her call light to request help and would sometimes push the call light and forget she had pushed it blaming it on her neighbor. CNA 2 stated Resident 1 did not have any fall prevention interventions in place prior to the fall on 1/30/25. (continued on next page)

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	055147	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/12/25 at 12:17 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was the unit supervisor for Station 5. LVN 2 stated Resident 1 had a history of falls prior to admission to the facility and was at risk for falls. LVN 2 stated Resident 1 had fallen on 1/30/25 and fractured her right hip. 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), dated 1/30/25 at 4:55 p.m. was reviewed, the SBAR indicated, . Change in Condition/s reported . Falls . Does the resident/patient have pain? Yes . When resident was heard yelling out for help. On entering room resident is noted to be on the floor of restroom . Resident is not wearing a brief, barefoot. When asked how she fell , resident stated she slipped in the restroom when getting out . Resident 1 ' s fall risk care plan dated 1/25/25 was reviewed. The care plan indicated, . The resident is at risk for unavoidable falls . admitted with injury . history of falling . Be sure The resident ' s call light is within reach and encourage (The resident to use it for assistance needed . Ensure that the resident is wearing appropriate footwear (shoes, non-skid socks) when ambulating . LVN 2 stated the SBAR indicated Resident 1 was barefoot when she was found on the floor of her bathroom. LVN 2 stated Resident 1 ' s care plan indicated she needed nonskid shoes or socks when ambulating and the intervention was not followed. LVN 2 stated the purpose of a care plan was to identify a resident ' s problem and goals and put interventions into place to meet those goals. LVN 2 stated all residents who were a high fall risk needed the interventions of proper footwear and the call light within reach, but each resident should also have person-centered, individualized interventions in place. LVN 2 stated, I had heard she was not good about using her call light. LVN 2 stated Resident 1 ' s interventions did not prevent her fall. Resident 1's MDS Assessment, Section GG, dated 1/31/25 (discharge assessment-lookback period reflects ability prior to fall on 1/30/25), was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 02 [Substantial maximal assistance] . D. sit to stand . code 01 [Dependent] . F. Toilet transfer . code 02 [Substantial/maximal assistance] . LVN 2 stated the MDS assessment indicated Resident 1 needed substantial help to go to the bathroom and Resident 1 ' s care plan did not address the amount of assistance required to use the bathroom safely. During a concurrent interview and record review on 2/12/25 at 3:21 p.m. with the Director of Nursing (DON), the DON stated she was new to the facility and not familiar with Resident 1. Resident 1 ' s fall risk care plan dated 1/25/25 was reviewed, the DON stated interventions in place prior to fall on 1/30/25 included call light in reach, encourage to use the call light and proper footwear applied to all residents. The DON stated care plans were important to let the staff know what care to provide to each individual resident. The DON declined to state if Resident 1 ' s care plans were person-centered. The DON stated, I think she was going to fall anyways, even with those interventions in place. Resident 1's MDS Assessment, Section GG, dated 1/31/25 (discharge assessment-lookback period reflects ability prior to fall on 1/30/25), was reviewed. The MDS Section GG indicated, . D. sit to stand . code 01 [Dependent] . F. Toilet transfer . code 02 [Substantial/maximal assistance] . The DON declined to state if the care plan addressed Resident 1 ' s assessed need for substantial/maximal assistance with toilet transfers according to the MDS. The DON declined to state if Resident 1 ' s care plan was individualized to meet Resident 1 ' s needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 2/7/2024, the P&P indicated, . A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional nurse is developed and implemented . interdisciplinary team (IDT) . develops and implements a comprehensive, person-centered care plan for each resident . care plan interventions are derived from analysis of the information gathered as part of the comprehensive assessment . describes the services that are to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being . reflects currently recognized standards of practice for problem areas and conditions . Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making . When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change . During a review of the facility ' s policy and procedure titled Falls and Fall Risk, Managing, dated 2/7/24, the P&P indicated, . Based on previous evaluations and current data, the nursing staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident . During a review of the facility ' s P&P titled Safety and Supervision of Residents, dated 1/2024, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis . When safety risks can not be completely eliminated, such as the risk for falls and related injuries, the facility staff shall develop strategies to mitigate the risk for injuries . Resident supervision is a core component of the approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs . 2. During a concurrent observation and interview on 3/4/25 at 11:37 a.m. with Resident 2, Resident 2 was dressed and groomed, sitting in his wheelchair in the hallway, his left arm was at side and flaccid. Resident 2 ' s left eyebrow and forehead were swollen. Resident 2 stated he had a history of a gunshot to the head and surgery which caused his left sided paralysis. Resident 2 stated he had a few falls at the facility since his admission (2/2/25). Resident 2 stated when he was lying in bed, he would suddenly become uncomfortable and need to sit up at the edge of the bed. Resident 2 stated it was difficult for him to balance when sitting at the edge of the bed by himself and he thought he was falling asleep causing him to fall forward. Resident 2 he had hit his head during the falls. Resident 2 stated he had two falls on the same day (2/20/25), the fall in the morning he had split his eyebrow open and later that night fell again causing the wound to open further. Resident 2 stated the facility sent him to the hospital for sutures because the wound would not stop bleeding. Resident 2 was able to recall the details of his emergency room visit. During a review of Resident 2 ' s Admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included fracture of left acetabulum (break in the hip socket), fracture of sacrum (bone located at the base of the spine), paraplegia, muscle weakness, abnormalities of gait and mobility and repeated falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s MDS assessment dated [DATE], indicated Resident 2 ' s BIMS assessment scored 07 of 15. The BIMS assessment indicated Resident 1 had a severe cognitive impairment on admission. During a review of Resident 2's MDS Assessment, Section GG-Functional Abilities, dated 2/8/25, was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 01 . D. sit to stand . code 01 . F. Toilet transfer . code 88 . Walk 10 feet . code 88 . During an interview on 3/4/35 at 11:55 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was assigned to Resident 2. CNA 2 stated Resident 2 was a high fall risk because he was known to sit himself up at the edge of the bed without assistance. CNA 2 stated Resident 2 did not have any fall interventions in place before his first fall. During a concurrent interview and record review on 3/4/25 at 12:35 p.m. with Registered Nurse (RN) 3, RN 3 stated she was assigned to Resident 2. Resident 2 ' s SBARs dated 2/15/25 at 4:40 a.m. indicated, . Resident was yelling for help writer walked in the room and saw patient kneeling on the floor next to his bed . resident stated I fell down, . I was sitting here on the bed and was falling asleep, and I fell forward luckily the wheelchair was in front of me, I think I hit my head on the chair. Resident 2 ' s SBAR dated 2/20/25 at 6:15 a. m. indicated, . Writer heard loud thump when passing medication . Resident was on the floor sitting next to his bed. Upon assessment noted skin tear to Left eyebrow . Resident stated that he was just sitting on the side of the bed and fell asleep. He said he fell forward and hit his head on the bedside table . Resident 2 ' s SBAR dated 2/20/25 at 10:35 p.m. indicated, . Resident stated he was sitting on the side of the bed and fell forward and hit his head on the bedside table . MD [Medical Doctor] notified and transfer to acute hospital . Writer heard some noise in the room . Resident was sitting on the floor right side of bed . resident has a laceration to the left side of forehead noted, bleeding noted . RN 3 stated Resident 2 ' s wound he sustained during the early morning fall had opened further after the fall that night so he was sent to the ED for sutures. RN 3 stated Resident 2 had five sutures to close the wound in the ED. Resident 2 ' s SBAR dated 2/26/25 at 11:37 p.m. indicated, . writer heard resident calling for help, upon entering room resident was found sitting on floor . abrasion to R [right] knee. Resident state he woke up and fell forward going under side table and hitting face against wall . RN 3 stated she had a floor mat placed next to the resident ' s bed, but he refused it. RN 3 stated Resident 2 had left sided weakness which makes him a high fall risk. RN 3 stated all four falls happened while Resident 2 sat unsupervised at the edge of his bed and fell forward to the floor. RN 3 stated Resident 2 needed supervision and assistance to sit at the edge of the bed safely and prevent falls. RN 3 was unable to answer how the facility had addressed Resident 2 ' s behavior of sitting at the edge of the bed unattended and his left sided weakness. RN 3 stated the weakness would make balance difficult and could affect his falling forward on the edge of the bed. Resident 2 ' s Fall Risk Assessment, dated 2/2/25 indicated Resident 2 was at risk for falls. Resident 2 ' s fall prevention care plan dated 2/15/25 indicated, . Had a fall on 2/15/25 . Pain assessment . neuro check . Monitor for delayed trauma . Modification of Bed mobility program . When [Resident 2] is wanting to sit on the side of the bed, staff to encourage activities of choice . monitor every shift for any COC [change of condition] . RN 3 stated she did not know what the bed mobility program was. RN 3 stated monitoring for delayed trauma and neuro checks would not prevent further falls and were not effective interventions. RN 3 stated the care plan interventions did not address Resident 2 ' s falls all happened when at the edge of the bed unsupervised or address his balance problem due to the left sided weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/4/25 at 4:00 p.m. with Minimum Data Set Coordinator (MDSC) 2, Resident 2 ' s BIMS was reviewed. MDSC 2 stated Resident 2 was confused when he was admitted , and his cognition had improved. Resident 2 ' s MDS section GG was reviewed, MDSC 2 stated the MDS indicated Resident 2 was dependent to sit at the edge of the bed. MDSC 2 reviewed Resident 2 ' s SBAR dated 2/15/25 and stated he was sitting at the edge of the bed and fell forward hitting his head on the wheelchair. MDSC 2 reviewed Resident 2 ' s care plans and was unable to locate a fall prevention care plan upon admission. MDSC 2 located a fall care plan dated 2/15/25 and stated the interventions indicated to assess for pain and neuro checks, monitor for delayed trauma and modification of bed mobility program. MDSC 2 stated she was unsure what the bed mobility program was but thought it possibly had to do with the CNA charting. MDSC 2 reviewed the CNA ' s tasks and stated the bed mobility program was not documented for Resident 2. MDSC 2 stated the care plan interventions were not effective because Resident 2 fell twice on 2/20/25. Resident 2 ' s SBARs for 2/20/25 were reviewed, MDSC 2 stated both falls happened while Resident 2 sat on the edge of his bed. Resident 2 ' s care plan dated 2/20/25 indicated, . Had a fall on 2/20/24 as a result of sitting on the side of the bed then falling asleep resulting in [Resident 2] losing his ability to maintain his stability . Assess pain every shift . Notify MD of fall and laceration . Obtain v/s [vital signs] as needed . ongoing monitoring . Send out to the acute . Social services to visit . Resident 2 ' s care plan dated 2/21/15 indicated, . Persistent to sit on the side of his bed ad lib [as often as desired]. At risk for falling that may cause injury that could result in death. Has poor safety awareness, [Resident 2] has unsteadiness while sitting on the side of the bed and has history of falling asleep causing him the inability to maintain stability . Redirect [Resident 2] while addressing any concerns he may have when he is falling asleep on the side of the bed . Social services to visit . MDSC 2 stated Resident 2 ' s reason for sitting at the edge of the bed and falling asleep while sitting there needed to be addressed in the care plan interventions. MDSC 2 stated the cause of why he needed to sit up suddenly and cannot wait for staff needed to be addressed. The IDT needed to find the root cause of him sitting at the edge of the bed because that was why he would fall. MDSC 2 stated she was not sure of what else would stop Resident 2 ' s falls besides finding the cause and addressing it. MDSC 2 stated the care plans do not address the amount of supervision or frequency of checks on him and should be specified. MDSC 2 stated the root cause of Resident 2 ' s falls needed to be figured out, so effective interventions could be put into place to prevent falls. During a concurrent interview and record review on 3/5/25 at 10:00 a.m. with Resident 2, Resident 2 sat in a w/c at his bedside. Resident 2 stated he would get very restless and uncomfortable, so he had to frequently sit up to the edge of the bed when he has those incidents. Resident 2 stated he thought he was falling because he was tired and thought he would start to fall asleep causing him to fall forward and was unable to use his left arm to catch himself. Resident 2 stated he would use the call light to ask for help getting to the side of the bed, but the staff were slow to respond so he would get to the edge of his bed alone. Resident 2 stated the staff would come in quickly after he fell . Resident 2 stated, I get anxious and desperate, so I get to the edge of the bed without them. During a concurrent interview and record review on 3/6/25 at 3:02 p.m. with the DON, the DON stated she was new to the facility and was not very familiar with Resident 2. Resident 2 ' s AR was reviewed. The DON stated Resident 2 had a diagnosis of paraplegia, The DON stated she attends the IDT meetings but was unsure if the IDT had discussed interventions regarding the left sided paralysis being a risk factor for Resident 2 ' s falls. The DON stated Resident 1 ' s left sided paralysis could have contributed to Resident 2 ' s balance issues and fall risk.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44899 Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for one of 12 sampled residents (Resident 3) when Resident 3 ' s low air loss (LAL - a special mattress used to prevent skin injuries, often occurring in individuals who are bedbound) mattress setting was not used according to the manufacturer ' s recommendation. This failure had the potential to result in Resident 3 to develop pressure ulcer (injury to the skin and underlying tissues by prolonged pressure on the skin) and placed Resident 3 at an increased risk for falls and discomfort. Findings: 1. During a review of Resident 3's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/3/25, the AR indicated, Resident 3 was admitted from an acute care hospital on 11/29/24 to the facility, with diagnoses that included Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Hypertension (high blood pressure), Pressure Ulcer of Sacral Region (triangular-shaped bone near the tailbone), and Anxiety Disorder (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness). During a review of Resident 3's Physician Order Summary Report (POS), dated 3/17/25, the POS indicated, . admitted under the care of [Name of Hospice Agency] . Order Date 11/29/24 . Low air loss mattress with pump every shift for wound management . Order Date 2/28/25 . During a review of Resident 3's Nursing Care Plan (CP), dated 2/28/25, the CP indicated, . The resident has potential for impairment to skin integrity r/t [related to] fragile skin, history of pressure ulcer . Interventions . Low air loss mattress . Date Initiated: 8/29/24 . During a concurrent interview and record review on 3/4/25 at 4:00 p.m., with the Minimum Data Set Coordinator (MDSC) 2, Resident 3 ' s photo of Low Air Loss (LAL) Mattress, dated 3/4/25, and Resident 3 ' s Monthly Weights, undated were reviewed. MDSC 2 stated the photo showed Resident LAL mattress was set at 320 lbs (pounds- unit of measurement). MDSC 2 stated Resident weight on 3/3/25 was 72 lbs. MDSC 2 stated the LAL mattress control clearly states the setting should be according to Resident ' s weight and it was not. MDSC 2 stated Resident 2 could potentially develop pressure ulcer or re-open healed wounds because of incorrect setting. MDSC 2 stated Resident 2 could potentially be uncomfortable lying in a firm LAL mattress. MDSC 2 stated Resident 2 ' s fall on 2/28/25 was probably cause by the LAL mattress incorrect setting. During an interview on 3/7/25 at 4:25 p.m., with the Director of Nursing (DON), the DON stated her expectation was for the licensed nurses to follow the manufacturer ' s recommendation for use of LAL mattress. The DON stated Resident 3 ' s recent fall could be attributed to the incorrect LAL mattress setting. The DON stated Resident 3 ' s incorrect LAL mattress setting was not effective in reducing pressure ulcer and could be uncomfortable. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, dated 2/24, the P&P indicated, . The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown . 14. Follow any air support surface mattress manufacture guidelines . During a review of the facility ' s document titled, Job Description: Floor Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring equipment is in good operating order . During a review of the facility's document titled, USER MANUAL [brand name] ' , dated 2018, the document indicated, . unit and mattress are intended to help reduce the incident of pressure ulcers while optimizing patient comfort . Pressure Adjust Knob adjustable by patient ' s weight . Turn the Pressure Adjust Knob to set a comfortable pressure level by using the weight scale as a guide .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 42123 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance to prevent falls for three of six sampled residents (Residents 1, 2 and 6) when: 1. Resident 1 was assessed as being a fall risk, had poor safety awareness and needed to be supervised while ambulating (walking) and the facility did not implement effective interventions to prevent falls, including adequate supervision, consistent with the resident ' s needs, goals and care. This failure resulted in Resident 1 ' s unwitnessed fall on 1/30/25, sustaining a right intertrochanteric fracture (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis [bony structure near the base of the spine]), pain, decreased mobility and required transportation to the emergency room and admission to the acute care hospital (ACH) for seven days. 2. Resident 2 had left sided paralysis (loss of movement), a history of falls, poor safety awareness and a known behavior of sitting at the edge of his bed unsupervised and the facility did not implement effective interventions including adequate supervision to meet the resident ' s needs. This failure resulted in Resident 2 ' s four unwitnessed falls: one on 2/15/25, two on 2/20/25 and one on 2/26/25. Resident 1 hit his head during a fall on 2/20/25 at 6:15 a.m. causing a skin tear to his left eyebrow and fell again on 2/20/25 at 9:35 p.m. hitting his head in the same area causing further trauma to the left eyebrow resulting in a laceration (cut or tear in the skin caused by blunt force). Resident 2 required transportation to the emergency room for sutures (threads used to close wounds) to repair the wound. 3. Resident 6 had an assessed need for supervision during transfers, poor safety awareness and a known behavior of self-transferring between her wheelchair and an armchair in the hallway and was left sitting unsupervised in an armchair in the hallway. This failure resulted in Resident 6 ' s unwitnessed fall on 3/5/25, sustaining an intertrochanteric fracture of the right hip, an acute fracture of the right radius (one of two long bones in the forearm, located on the thumb side) and a laceration to her left lower lip. Resident 6 was admitted to the ACH from 3/5/25 until 3/12/25 where she had an open reduction internal fixation (ORIF-surgical procedure to repair broken bones) of the right hip on 3/7/25 and required an arm splint on her right arm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Because of the serious actual harm to Residents 1, 2 and 6 and potential serious harm to Residents 3, 4 and 5 and the serious potential harm to all residents related to the facility's inability to implement an effective program to prevent falls, an Immediate Jeopardy (IJ-a situation in which non-compliance with one or more regulatory requirements has caused or is likely to cause serious injury, harm, impairment, or death to a resident) situation was identified at a scope and severity of K (pattern of non-compliance when multiple residents are affected) and an IJ was called on 3/5/25, at 3:49 p.m., under Code of Federal Regulations (CFR) 483.25 (F689) with the facility's Administrator (ADM), Administrator Consultant (ADMC) Director of Nursing (DON), and Director of Nursing Consultant (DONC). The CMS IJ Template was shared with the facility on 3/5/25 at 3:49 p.m. The facility submitted a Plan of Removal (POR) version 1 on 3/6/25 at 10:12 a. m. The POR version 1 was not acceptable. The facility submitted a POR version 2 on 3/6/25, at 3:59 p.m. The IJ POR included: 1) facility added 1:1 support and supervision while awake and will remain in sight of Residents 1 and 2. 2) Staff will assist Resident 2 with stability and balance while sitting on side of the bed to minimize risk for falling. 3) Staff will assist Resident 1 with individual toileting plan including upon waking, before and after meals, before bed and every two hours as needed. 4) Resident 6 will be placed on a 1:1 while awake after she returns to the facility, assist with safe transfers, cueing and provide direct care for impulsive attempts to rise or transfer. 5) Facility identified resident falls for 2025, and IDT reviewed Root Cause (RC) Analysis of accident hazards, supervision and assistive devices to prevent avoidable accidents and have updated care plans with person-centered interventions which will be reviewed weekly by the IDT. 6) Facility increased CNA staffing on stations 5 & 6 during the evening and night shifts as identified during RC analysis for falls. 7) The facility assigns monitor staff daily including each unit supervisor for every 15-minute safety checks on identified residents with falls. 8) The activity department added additional snack and crafts cart and staff support during evening hours for identified high fall risk residents with actual falls. 9) Director of Staff Development (DSD) initiated in-service for direct care staff on each shift with specific focus on resident interventions to reduce falls and injuries from falls. The IJ Plan of Removal Version 2 was accepted on 3/7/25 at 9:15 a.m. While onsite, the surveyors validated the POR implementation action items through observations, interview and record reviews and confirmed that all POR action interventions to address the IJ situation were fully implemented. The IJ was removed on 3/7/25 at 4:03 p.m., with the ADM, ADMC, DON and Director of Staff Development (DSD). After removal of the IJ, the facility remained in substantial non-compliance. Findings: 1. During a review of Resident 1 ' s ACH document titled Case Management Discharge Summary/Orders Report, dated 2/7/25, the note indicated, . admitted : 1/31/2025 . discharge date : 2/7/2025 . Slip and fall coming out of bathroom landing on her right hip . Admission Diagnoses: Intertrochanteric fracture . Procedures . Open Reduction Internal Fixation [surgical procedure that treats intertrochanteric hip fractures] Femur (Right) . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 1 ' s Admission Record (AR) undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included wedge compression fracture of T5-T6 vertebra (a break in the bones in your back that stack up to form your spine part of the vertebra [bones that make up the backbone] collapses), COPD (chronic obstructive pulmonary disease-chronic lung disease causing difficulty in breathing), Chronic respiratory failure (medical condition where the blood has low oxygen [colorless odorless gas essential to life] levels), Parkinsonism (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), abnormalities of gait (persons manner of walking) and mobility, history of falling and muscle weakness. During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 12 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had a moderate cognitive impairment. During a review of Resident 1's MDS Assessment, Section GG-Functional Abilities, dated 1/23/25, was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 01 [Dependent (when someone needs another person ' s help to move)] . D. sit to stand . code 88 [Not attempted due to medical condition or safety concerns] . F. Toilet transfer . code 88 . Walk 10 feet . code 09 [Not applicable-Not attempted and the resident did not perform this activity] . During a concurrent observation and interview on 2/12/25 at 9:47 a.m. with Resident 1, Resident 1 was lying in bed, the bed was in the lowest position. Resident 1 had involuntary tremors of her arms and legs. Resident 1 stated she was in pain and pointed to her right hip. Resident 1 stated she had recently fallen in the bathroom and became tearful and visually upset. Resident 1 stated I just fell [on 1/30/25]. During an interview on 2/12/25 at 10:04 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to Resident 1. CNA 1 stated she had taken care of Resident 1 before her fall on 1/30/25. CNA 1 stated Resident 1 required supervision and touch assistance (caregiver assistance intermittent or continuous touch to help maintain balance during activity) for balance and safety while ambulating to the bathroom before the fall. CNA 1 stated she would stay nearby when Resident 1 was in the bathroom because the resident was a high fall risk and was forgetful. CNA 1 stated Resident 1 would not remember to use the call light and wait for help to go back to bed. CNA 1 stated Resident 1 did not have any fall interventions in place prior to her fall. During an interview on 2/12/25 at 11:31 a.m. with CNA 2, CNA 2 stated she was familiar with Resident 1. CNA 2 stated Resident 1 would not consistently use her call light to request help and would sometimes push the call light and forget she had pushed it blaming it on her neighbor. CNA 2 stated Resident 1 did not have any fall prevention interventions in place prior to the fall on 1/30/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 2/12/25 at 12:17 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was the unit supervisor. LVN 2 stated Resident 1 had fallen on 1/30/25 and fractured her right hip. 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), dated 1/30/25 at 4:55 p.m. was reviewed, the SBAR indicated, . Change in Condition/s reported . Falls . Does the resident/patient have pain? Yes . resident was heard yelling out for help. On entering room resident is noted to be on the floor of restroom. Resident is on the floor in-between the door way - facing the door-laying on left side trying to hold herself up with left arm, legs are bent at the knees. Resident is not wearing a brief [absorbent underwear to manager urine leakage], barefoot. When asked how she fell , resident stated she slipped in the restroom when getting out . Provider Notification . Recommendation of Primary Clinician(s) . STAT(urgent) X-ray of the right hip, right femur, right knee, right fibula/tibia (are both bones in the lower leg, with the tibia being the larger, weight-bearing shinbone on the inside of the leg, while the fibula is the smaller bone on the outside, primarily providing stability to the ankle joint) . Pain Status Evaluation . Rate pain on a scale of 0 to 10 (0=no pain, 4-5 moderate pain, 10=excruciating pain) . 8/10 . Acute [sudden sharp pain] . right leg . Resident 1 ' s fall risk care plan dated 1/25/25 was reviewed. The care plan indicated, . The resident is at risk for unavoidable falls . admitted with injury . history of falling . Be sure The resident ' s call light is within reach and encourage (The resident to use it for assistance needed . Ensure that the resident is wearing appropriate footwear (shoes, non-skid socks) when ambulating . LVN 2 stated the SBAR indicated Resident 1 was barefoot when she was found on the floor of her bathroom. LVN 2 stated according to the care plan Resident 1 should have been wearing some sort of nonskid shoes or socks when ambulating and the intervention was not followed. LVN 2 stated care plans were used to identify a resident ' s problem and goals and put interventions into place to meet those goals. LVN 2 stated all residents who were a high fall risk needed the interventions of proper footwear and call light within reach, but each resident should also have person-centered, individualized interventions in place. LVN 2 stated, I had heard she was not good about using her call light. LVN 2 stated Resident 1 ' s interventions did not prevent her fall. LVN 2 stated Resident 1 had a history of falls prior to admission to the facility and was at risk for falls. Resident 1's MDS Assessment, Section GG, dated 1/31/25 was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 02 [Substantial maximal assistance] . D. sit to stand . code 01 [Dependent] . F. Toilet transfer . code 02 [Substantial/maximal assistance] . LVN 2 stated the MDS assessment indicated Resident 1 needed substantial help to go into the bathroom prior to her fall on 1/30/25. LVN 2 stated the SBAR and progress notes did not indicate how Resident 1 wound up in the bathroom by herself without staff knowledge. LVN 2 stated Resident 1 should not have been in the bathroom without staff supervision. Resident 1 ' s Radiology Note, dated 1/31/25 at 2:50 a.m. indicated, . Received xray results . MD notified . Resident 1 ' s SBAR, dated 1/31/25 at 3:08 a.m., indicated, . Primary Care Provider responded with the following feedback . May send resident out to hospital for further evaluation . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 2/12/25 at 3:01 p.m. with CNA 3, CNA 3 stated she was assigned to Resident 1 at the time of her fall on 1/30/25. CNA 3 stated Resident 1 was found on the floor in her bathroom by Registered Nurse (RN) 2. CNA 3 stated she had passed Resident 1 ' s room and heard a commotion and when she walked into the room, Resident 1 was on the floor shouting and there were other staff members with her. CNA 3 stated Resident 1 was in extreme pain which made it was difficult to transfer her back to bed because she would not move. CNA 3 stated Resident 1 was barefoot when they found her in the bathroom after she fell and was not good about wearing nonskid footwear. CNA 3 stated Resident 1 needed help transferring, and she was unsure how she wound up in the bathroom alone. CNA 3 stated when she would take Resident 1 to the bathroom, she always stayed in the room with the door cracked open to make sure Resident 1 did not fall. CNA 3 stated Resident 1 was alert and oriented but forgetful and did not remember to use her call light. During a concurrent interview and record review on 2/12/25 at 3:21 p.m. with the Director of Nursing (DON), the DON stated she was new to the facility and not familiar with Resident 1. The DON reviewed Resident 1 ' s Post-Fall Review, dated 1/30/25, the note indicated, . Date and Time of fall . 1/30/25 16:44 [4:55 p.m.] . Resident is laying on left side . legs are bent at an angle. Resident is not wearing a brief, barefoot . IDT [Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident] Review and Summary of Root Cause . IDT met to review the fall that happened . Recommendations . INDIVIDUAL SCHEDULED TOILETING PLAN: Assist resident with toileting at the following times . Pain assessment q [every] shift . Follow up with ortho [orthopedic physician] . Verbal education to wait for staff assistance prior to transfer . IDT Members Participating . ADON [Assistant Director of Nursing . UM [Unit Manger] . Activity . [note signed by DON on 2/12/25 . The DON stated the note did not indicate what the IDT determined to be the root cause of Resident 1 ' s fall. The DON stated, I think she was going to fall anyways, even with those interventions in place. During an interview on 2/12/25 at 4:17 p.m. with the Administrator (ADM), the ADM stated he did not attend the post fall IDT after Resident 1 ' s fall. The ADM was not aware of the specifics of Resident 1 ' s fall and stated anything clinical was the responsibility of the DON and clinical staff. During a telephone interview on 2/13/25 at 9:36 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 had falls before admission to the skilled nursing facility. FM 1 stated Resident 1 was not safe going to the bathroom without help. FM 1 stated she was not sure if Resident 1 had gotten up alone but would have needed help because she was not safe to walk on her own because she had tremors to her arms and legs due to Parkinson ' s Disease. FM 1 stated Resident 1 was very forgetful and would not call the nurses for help. FM 1 stated Resident 1 told her she fell because there was something wet on the floor in the bathroom. During a telephone interview on 2/18/25 at 4:52 p.m. with Registered Nurse (RN) 2, RN 2 stated she found Resident 1 barefoot lying on the bathroom floor and was shouting for help. RN 2 stated Resident 1 required supervision and stand by assistance when ambulating. RN 2 stated Resident 1 would be reminded to use the call light but was forgetful and did not use it. RN 2 stated Resident 1 must have walked to the bathroom by herself. RN 2 stated she did not recall if Resident 1 was in severe pain when found on the floor. Resident 1 ' s SBAR, dated 1/30/25 at 4:55 p.m., written by RN 2 was read to her. The note indicated, . Pain Status Evaluation . 8/10 . Acute . right leg . RN 2 declined to state if Resident 1 had outward signs of severe pain when found on the floor. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 1 ' s PT [physical therapy] Evaluation & Plan of Treatment, dated 1/21/25, the note indicated, . Lower Extremity [legs] . RLE [right lower extremity] = 2/5 [muscle strength grading score on scale of 1-5 (2/5 indicates muscle can move through full range of motion but only with gravity eliminated-considered poor strength)] . LLE [left lower extremity] = 2/5 . Pain with Movement = 9/10 [pain scale-numeric scale 1-10 with 1/10 being no pain and 10/10 being severe pain] . Frequency = Constant . During a review of the facility ' s policy and procedure titled Falls and Fall Risk, Managing, dated 2/7/24, the P&P indicated, . Based on previous evaluations and current data, the nursing staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . Resident conditions that may contribute to the risk of falls . other cognitive impairment . pain . lower extremity weakness . medication side effects . functional impairments . Medical factors that contribute to the risk of falls . heart failure . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident . During a review of the facility ' s P&P titled Safety and Supervision of Residents, dated 1/2024, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis . When accident hazards are identified, the facility staff shall review the events in an attempt to identify the root-cause and possible associated hazards . When safety risks can not be completely eliminated, such as the risk for falls and related injuries, the facility staff shall develop strategies to mitigate the risk for injuries . Resident supervision is a core component of the approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs . 2. During a concurrent observation and interview on 3/4/25 at 11:37 a.m. with Resident 2, Resident 2 was dressed and groomed, sitting in his wheelchair in the hallway, his left arm was flaccid (limp). Resident 2 ' s left eyebrow and forehead were swollen. Resident 2 stated he had a history of a gunshot to the head and surgery which caused his left sided paralysis. Resident 2 stated he had fallen a few times since his admission to the facility (on 2/2/25). Resident 2 stated when he was in bed, he would suddenly become very uncomfortable and need to sit up at the edge of the bed. Resident 2 stated it was difficult for him to balance when sitting at the edge of the bed by himself because of his paralysis and he would doze off and fall forward. Resident 2 stated he had hit his head during each fall, and he fell twice on the same day (on 2/20/25), causing a wound to his left eyebrow. Resident 2 stated during the fall on the morning of 2/20/25, he had sustained a small cut above his eyebrow. Resident 2 fell again on 2/20/25 at night and his wound became a deeper cut and did not stop bleeding, so he was sent to the hospital for sutures. During a review of Resident 2 ' s AR, undated, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included fracture of left acetabulum (break in the hip socket), fracture of sacrum (bone located at the base of the spine), paraplegia (inability to voluntarily move parts of the body), muscle weakness, abnormalities of gait and mobility and repeated falls. During a review of Resident 2 ' s MDS assessment dated [DATE], indicated Resident 2 ' s BIMS assessment scored 07 of 15. The BIMS assessment indicated Resident 2 had a severe cognitive impairment on admission. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 2 ' s ACH document titled ED Provider Notes, dated 2/20/25, the notes indicated, . Two ground level falls today . first fall was this morning . during which he slipped out of bed and struck his head . at 23:30 [11:30 p.m.] he slipped out of his bed once again prompting visit to the ED . he is bed bound . presents for a laceration to the left eyebrow . Lac [laceration] repaired in ED . During an interview on 3/4/25 at 11:55 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was familiar with Resident 2. CNA 2 stated Resident 2 was a high fall risk because he was known to get himself up to the edge of the bed without assistance, had left sided weakness, and a history of falling. CNA 2 stated Resident 2 did not have any fall prevention interventions in place. During a concurrent interview and record review on 3/4/25 at 12:35 p.m. with RN 3, RN 3 stated she was assigned to Resident 2. Resident 2 ' s Change in Condition Evaluation (CIC-documents short term or significant change in resident ' s health or functioning), dated 2/15/25 at 4:40 a.m., indicated, . Resident was yelling for help writer walked in the room and saw patient kneeling on the floor next to his bed . resident stated I fell down, . I was sitting here on the bed and was falling asleep, and I fell forward luckily the wheelchair was in front of me, I think I hit my head on the chair . Resident 2 ' s CIC, dated 2/20/25 at 6:15 a. m. indicated, . Writer heard loud thump when passing medication . Resident was on the floor sitting next to his bed. Upon assessment noted skin tear to Left eyebrow . Resident stated that he was just sitting on the side of the bed and fell asleep. He said he fell forward and hit his head on the bedside table . Resident 2 ' s Post Fall Review, dated 2/20/25 at 10:52 p.m., indicated , . Date and Time of Fall . 2/20/25 . 21:35 [9:35 p.m.] . Resident 2 ' s CIC, dated 2/20/25 at 10:35 p.m., indicated, . Resident stated he was sitting on the side of the bed and fell forward and hit his head on the bedside table . MD [Medical Doctor] notified and transfer to acute hospital . Writer heard some noise in the room . Resident was sitting on the floor right side of bed . resident has a laceration to the left side of forehead noted, bleeding noted . RN 3 stated she took care of Resident 2 on the day shift after his first fall on 2/20/25. RN 3 stated Resident 2 had a skin tear above his eyebrow at that time and did not require sutures. RN 3 stated Resident 2 fell during the evening/night shift report on 2/20/25, hit his left eyebrow again and it became a laceration, so he was sent out to the emergency room for sutures. RN 3 stated Resident 2 had left sided weakness and poor balance which made him a high fall risk. RN 3 stated all of Resident 2 ' s falls happened while he sat unsupervised at the edge of his bed and fell forward to the floor. Resident 2 ' s fall care plan dated 2/4/25 was reviewed, the care plan indicated, . The resident is at risk for unavoidable falls with injury r/t [related to] repeated falls . the resident is (High, Moderate, Low) risk for unavoidable falls with injury r/t limited mobility . Interventions . Anticipate and meet the resident ' s needs . RN 3 stated the care plan was not edited to indicate Resident 2 ' s fall risk level and the intervention to anticipate and meet needs was not specific and person centered. Resident 2 ' s fall care plan dated 2/15/25 indicated, . Had a fall on 2/15/25 . Pain assessment . neuro check . Monitor for delayed trauma . Modification of Bed mobility program . When [Resident 2] is wanting to sit on the side of the bed, staff to encourage activities of choice . monitor every shift for any COC [change of condition] . RN 3 stated she did not know what the bed mobility program was. RN 3 was unable to state how the care plan interventions addressed Resident 2 ' s left sided weakness, balance issues and need for supervision while sitting on the edge of the bed. RN 3 stated Resident 2 needed supervision and assistance to sit safely at the edge of the bed. Resident 2 ' s CIC, dated 2/26/25 at 11:37 p.m. indicated, . writer heard resident calling for help, upon entering room resident was found sitting on floor . abrasion to R [right] knee. Resident state he woke up and fell forward going under side table and hitting face against wall . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 3/4/25 at 4:00 p.m. with Minimum Data Set Coordinator (MDSC) 2, Resident 2 ' s MDS assessment Section GG-Functional Abilities, dated 2/8/25 was reviewed. The MDS Assessment indicated, .C. lying to sitting on side of bed . code 01 . D. sit to stand . code 01 . F. Toilet transfer . code 88 . Walk 10 feet . code 88 . MDSC 2 stated the MDS indicated Resident 2 was dependent to sit at the edge of the bed. MDSC 2 reviewed Resident 2 ' s CIC, dated 2/15/25 and stated he was sitting at the edge of the bed and fell forward hitting his head on the wheelchair. MDSC 2 reviewed Resident 2 ' s fall care plan dated 2/4/25 and stated it did not specify if Resident 2 was at high, moderate or low risk for falls and the intervention was to anticipate and meet the resident ' s needs. MDSC 2 stated the intervention was not person centered or effective because it did not prevent his fall on 2/15/25. Resident 2 ' s fall care plan interventions were updated on 2/17/25 to include: encourage non-slip footwear, monitor for delayed trauma, pain assessment, anticipate and meet resident ' s needs, keep bed low, educate about safety and encourage activities. MDSC 2 stated the care plan interventions were not effective because Resident 2 fell twice on 2/20/25. MDSC 2 reviewed both of Resident 2 ' s CIC, dated 2/20/25 and stated both falls happened while Resident 2 sat unsupervised on the edge of his bed. Resident 2 ' s care plan dated 2/20/25 indicated, . Had a fall on 2/20/24 as a result of sitting on the side of the bed then falling asleep resulting in [Resident 2] losing his ability to maintain his stability . Assess pain every shift . Notify MD of fall and laceration . Obtain v/s [vital signs] as needed . ongoing monitoring . Send out to the acute [acute care hospital] . Social services to visit . MDSC 2 stated the interventions did not address the cause of Resident 2 ' s falls or how to prevent a recurrence. Resident 2 ' s care plan dated 2/21/25 indicated, . Persistent to sit on the side of his bed ad lib [as often as desired]. At risk for falling that may cause injury that could result in death. Has poor safety awareness, [Resident 2] has unsteadiness while sitting on the side of the bed and has history of falling asleep causing him the inability to maintain stability . Redirect [Resident 2] while addressing any concerns he may have when he is falling asleep on the side of the bed . Social services to visit . MDSC 2 stated the root cause of Resident 2 ' s need to sit up suddenly without supervision needed to be figured out so effective fall interventions could be put into place. MDSC 2 stated Resident 2 ' s care plans were not person-centered and did not address the amount or frequency of supervision he required. During a concurrent observation and interview on 3/5/25 at 10:00 a.m. with Resident 2, Resident 2 sat in a wheelchair at bedside. Resident 2 stated while in bed he would suddenly become very restless and uncomfortable, so he had to sit up at the edge of the bed frequently. Resident 2 stated he thought his falls were caused by sitting at the edge of the bed and dozing off, unable to use his left arm to catch himself. Resident 2 stated he used the call light to ask for help getting to the edge of the bed, but the staff were slow to respond, and he could not wait. Resident 2 stated, I get anxious and desperate, so I get to the edge of the bed without them. Resident 2 stated the staff would come in quickly after he fell . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 3/5/25 at 10:15 a.m. with the Director of Rehabilitation (DOR), Resident 2 ' s physical therapy (PT) evaluation dated 2/3/25 was reviewed. The PT evaluation indicated, . history of gunshot wound to the head requiring an operation with residual [remaining side effects of a condition after it has been treated] L [left] side paralysis . Patient presents with deficits in strength, balance, safety, postural [position of the body] instability . the patient is at risk for: falls and further decline in function . The DOR stated the PT evaluation indicated Resident 2 needed minimal assistance for static sitting (maintain single posture), but he needed help with dynamic sitting (when you move while sitting). The DOR stated Resident 2 had paralysis on the left side of his body and his left arm was flaccid from the gunshot and brain surgery. The DOR stated the left sided paralysis would not improve completely. The DOR stated Resident 2 would always have balance issues and require assistance to sit safely. The DOR stated as soon as Resident 2 moved while sitting, he would fall to the left side which increased his fall risk. The DOR stated she spoke to Resident 2 ' s Responsible Party (RP) and was told he had a history of sitting at the edge of his bed and falling at home. During an interview on 3/5/25 at 10:28 a.m. with the Physical Therapy Assistant (PTA), the PTA stated she worked with Resident 2 daily. The PTA stated Resident 2 fell twice on 2/20/25. The PTA stated she saw Resident 2 after his first fall on 2/20/25 and he told her he sat at the edge of the bed and started to fall asleep, falling forward. The PTA stated Resident 2 was impulsive and was frequently leaning forward, sitting at the edge of the bed unsupervised when she picked him up for therapy. The PTA stated the resident needed supervision to sit at the edge of the bed safely. During a review of Resident 2 ' s Post-Fall Review, dated 2/15/25 at 4:40 p.m., the note indicated, . IDT met to review the incident happened on 2/15/2025 . Root cause: Falling asleep while sitting up. Recommendations: 1. Pain assessment . Neuro check . Monitor for delayed trauma . Modification of bed mobility program . When [Resident 2] is wanting to sit on the side of the bed, staff to encourage activities . signed by the DON on 2/17/25. During a review of Resident 2 ' s Post-Fall Review, dated 2/20/25 at 6:15 a.m., the note indicated, . IDT met to review Resident ' s fall on 2/20/2025 [first fall] . Resident was sitting on the edge of the bed and started to fall asleep. He fell forward and hit his head on the edge of the bedside table. He received a skin tear to his Left Eyebrow with some bleeding . IDT recommends: When Resident is observed at edge of bed assist him to lie down in the bed as he allows . signed 2/20/25 [TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42123 Based on observation, interview, and record review, the facility failed to provide sufficient staff with the appropriate competencies and skill sets to provide nursing services to ensure residents receive services to maintain their highest practicable physical, mental, and psychosocial well-being when seven of seven sampled nursing staff (Registered Nurse [RN] 1, RN 2, Licensed Vocational Nurse [LVN] 1, LVN 2, Certified Nursing Assistant [CNA] 1, CNA 2, CNA 3) did not have their fall prevention competency (ability to do something successfully) skills checked within the last year and there were 42 falls between 1/1/25 and 2/12/25. This failure resulted in one of three sampled residents (Resident 1 ' s) unwitnessed fall on 1/30/25, sustaining an intertrochanteric fracture (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis), pain, decreased mobility and required transportation to the emergency room and admission to the acute care hospital (ACH) for seven days and placed other residents at risk for falls with significant injury. (cross reference F689) Findings: During a concurrent observation and interview on 2/12/25 at 9:47 a.m. with Resident 1, Resident 1 was lying in bed, the bed was in the lowest position. Resident 1 had involuntary tremors of her arms and legs. Resident 1 stated she was in pain and pointed to her right hip. Resident 1 stated she had recently fallen in the bathroom and became tearful and visually upset. Resident 1 stated I just fell [on 1/30/25]. During a review of Resident 1 ' s ACH document titled Case Management Discharge Summary/Orders Report, dated 2/7/25, the note indicated, . admitted : 1/31/2025 . discharge date : 2/7/2025 . Slip and fall coming out of bathroom landing on her right hip . Admission Diagnoses: Intertrochanteric fracture . Procedures . Open Reduction Internal Fixation [surgical procedure that treats intertrochanteric hip fractures] Femur (Right) . During an interview on 2/12/25 at 3:01 p.m. with CNA 3, CNA 3 stated she was assigned to Resident 1 at the time of her fall on 1/30/25. CNA 3 stated Resident 1 was found on the floor in her bathroom. CNA 3 stated she had passed Resident 1 ' s room and heard a commotion and when she walked into the room, Resident 1 was on the floor shouting and there were other staff members with her. CNA 3 stated Resident 1 was in extreme pain which made it was difficult to transfer her back to bed because she would not move. CNA 3 stated Resident 1 was barefoot when they found her in the bathroom and was not good about wearing nonskid footwear. CNA 3 stated Resident 1 needed help transferring, and she was unsure how she wound up in the bathroom alone. CNA 3 stated Resident 1 did not have fall prevention interventions in place at the time of her fall on 1/30/25. During an interview on 2/12/25 at 2:22 p.m. with the Director of Staff Development (DSD), the DSD stated she held a recent fall prevention in-service because the facility had a large number of falls. The DSD stated she had a difficult time encouraging the staff to attend the in-service. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/25 at 3:21 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for the staff to attend the in-services provided by the DSD. The DON stated she was new to the facility and was not able to comment on how the DSD measured staff competency. During a concurrent interview and record review on 2/12/25 at 4:01 p.m. with the DSD, the facility ' s in-service titled Fall/Accident Prevention & Safe Transfer, dated 1/28/25, was reviewed. The DSD stated the sign in sheet indicated RN 1, RN 2, LVN 1 and LVN 2 did not attend the in-service. The DSD stated CNAs 1, 2 and 3 attended. The DSD stated, I do not have anything to show that the staff had actually met the competency. The DSD stated she should have tested staff competency after the in-service to verify they possess the knowledge and skills needed to prevent falls. The DSD stated she did not have any other in-services for fall prevention with staff competencies within the past year. During a telephone interview on 2/18/25 at 4:52 p.m. with Registered Nurse 2, RN 2 stated she was the nurse on duty when Resident 1 fell on [DATE]. RN 2 stated Resident 1 was found by staff on the floor in the bathroom after an unwitnessed fall. RN 2 stated she did not attend a fall prevention in-service. During a review of the facility ' s job description titled Floor Nurse, undated, the job description indicated, . purpose of your job position is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards . Monitoring residents that are at risk for falls . Abiding with all facility policies and procedures . Attending annual facility in-service training programs . The facility was unable to provide a policy and procedure for staff competencies.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 42123 Based on interview and record review, the Administrator (ADM) failed to provide consistent administrative oversight and resources to ensure residents received adequate supervision and care planning when the ADM was aware of 63 resident falls between 1/1/25 and 3/4/25 and did not establish an effective fall prevention program. This failure resulted in three of six sampled residents (Residents 1, 2 and 6) having unwitnessed falls with injury requiring transportation to the acute care hospital (ACH) for treatment and placed other residents at risk for falls with injury. (cross reference F689) Findings: During a review of the facility ' s document titled Incidents By Incident Type, dated 1/1/25 to 3/4/25, the document indicated, . Total ' Fall ' Incidents: 64 . One fall was crossed out in error. During a review of Resident 1 ' s ACH document titled Case Management Discharge Summary/Orders Report, dated 2/7/25, the note indicated, . admitted : 1/31/2025 . discharge date : 2/7/2025 . Slip and fall coming out of bathroom landing on her right hip . Admission Diagnoses: Intertrochanteric fracture . Procedures . Open Reduction Internal Fixation [surgical procedure that treats intertrochanteric hip fractures] Femur (Right) . During a concurrent interview and record review on 2/12/25 at 12:17 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was the unit supervisor for Station 5. LVN 2 stated Resident 1 had fallen on 1/30/25 and fractured her right hip. 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), dated 1/30/25 at 4:55 p.m. was reviewed, the SBAR indicated, . Change in Condition/s reported . Falls . Does the resident/patient have pain? Yes . resident was heard yelling out for help. On entering room resident is noted to be on the floor of restroom. Resident is on the floor in-between the door way - facing the door- laying on left side trying to hold herself up with left arm, legs are bent at the knees. Resident is not wearing a brief, barefoot. When asked how she fell , resident stated she slipped in the restroom when getting out . Rate pain on a scale of 0 to 10 (0=no pain, 4-5 moderate pain, 10=excruciating pain) . 8/10 . Acute . right leg . LVN 2 stated the SBAR indicated Resident 1 was barefoot when she was found on the floor of her bathroom. LVN 2 stated, I had heard she was not good about using her call light. LVN 2 stated she was unable to tell from the documentation how Resident 1 wound up in the bathroom by herself without staff knowledge. LVN 2 stated Resident 1 should have been assisted to the bathroom and worn non-skid footwear to prevent her fall. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 2/12/25 at 3:21 p.m. with the Director of Nursing (DON), the DON stated she was new and started working at the facility on 2/3/25, after Resident 1 ' s fall. The DON reviewed Resident 1 ' s Post-Fall Review, dated 1/30/25, the note indicated, . Date and Time of fall . 1/30/25 16:44 [4:55 p.m.] . Resident is laying on left side . legs are bent at an angle. Resident is not wearing a brief, barefoot . IDT [Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident] Review and Summary of Root Cause . IDT met to review the fall that happened . Recommendations . INDIVIDUAL SCHEDULED TOILETING PLAN: Assist resident with toileting at the following times . Pain assessment q [every] shift . Follow up with ortho [orthopedic physician] . Verbal education to wait for staff assistance prior to transfer . IDT Members Participating . ADON [Assistant Director of Nursing . UM [Unit Manger] . Activity . [note signed by DON on 2/12/25] . The DON was unable to say what the IDT determined to be the root cause of Resident 1 ' s fall. The DON stated, I think she was going to fall anyways, even with those interventions in place. The DON stated she was aware there were multiple falls in the facility but did not have time to familiarize herself with the facility ' s policies and procedures (P&P) yet. During an interview on 2/12/25 at 4:01 p.m. with the Director of Staff Development (DSD), the DSD stated she was aware the facility had a high number of resident falls. The DSD stated she held a fall prevention in-service for the staff on 1/28/25 to address the high fall rate. The DSD stated she did not test the staff ' s competency after the in-service. During a concurrent interview and record review on 2/12/25 at 4:17 p.m. with the ADM, the facility ' s document titled Incidents By Incident Type, dated 1/1/25 to 2/12/25 was reviewed. The document indicated there were 31 falls in 1/2025 and 11 falls between 2/1/25-2/12/25. The ADM stated he was aware there were issues with the number of resident falls. The ADM stated the falls were a clinical issue and would fall under the DON ' s responsibility. The ADM was unaware of the details regarding Resident 1 ' s fall with injury on 1/30/25. The ADM stated he did not attend the fall IDT meetings because it was the clinical staff ' s responsibility. During an interview on 3/5/25 at 2:37 p.m. with the ADM, the ADM stated resident falls were discussed between clinical staff in the IDT. The ADM stated, There is a lot that goes on in this building. The ADM stated the Director of Nursing was in charge of resident falls and the IDT. The ADM stated, I am not a nurse, so I am not involved in that part, [the] clinical part of the meeting. During a review of the facility ' s job description titled Administrator, undated, the job description indicated, . primary purpose of your job position is to direct the day-to-day functions of the facility . Ensure that all employees, residents, visitors and the general public follow established policies and procedures . Assume the administrative authority, responsibility and accountability of directing the activities and programs of the facility . Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed . Review accident/incident reports and establish an effective accident prevention program . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility ' s P&P titled Safety and Supervision of Residents, dated 1/2024, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis . When accident hazards are identified, the facility staff shall review the events in an attempt to identify the root-cause and possible associated hazards . When safety risks can not be completely eliminated, such as the risk for falls and related injuries, the facility staff shall develop strategies to mitigate the risk for injuries . Resident supervision is a core component of the approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 44899 Based on interview and record review, the facility failed to follow its hospice (care that focuses on the quality of life for people who are experiencing an advanced, life-limiting illness) policy and procedures (P&P) for two of 12 sampled residents (Resident 8 and Resident 14) when Resident 8 and Resident 14 were receiving hospice services with unsigned hospice agreement. This failure had the potential to place Resident 8 and Resident 14 at risk of not receiving appropriate medical, physical, psychosocial, and spiritual support to manage symptoms associated with terminal illness. Findings: During a concurrent interview and record review on 3/5/25, at 2:15 p.m., with the Administrator (ADM), the facility's Hospice Agreement with [Name of Hospice Agency], dated 6/16/16 was reviewed. The hospice agreement indicated, . IN WITNESS WHEREOF, each intending to be legally bound, have duly executed this Addendum as of the day, month and year first above written . Hospice Services include: (1) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician . (iv) counselling services . (vii) medical supplies; (viii) drugs and biologicals . The ADM stated there was no signature from [Name of Hospice Agency] authorized representative. The ADM stated the hospice agreement must be signed by both parties prior to initiating hospice services for Resident 8. The ADM stated, without the signature the hospice agreement was not valid. The ADM stated he [ADM] was responsible in ensuring contracts with outside service providers, including hospice, were reviewed and signed prior to initiating care or service and it was not done. During a concurrent interview and record review, on 3/5/25, at 2:21 p.m., with the ADM, the facility's hospice agreement with [Name of Hospice Agency] , dated 3/30/22 was reviewed. The hospice agreement indicated, . IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of 3/30/22 . (6) A delineation of the hospice ' s responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling; social work; provision of medical supplies, durable medical equipments and drugs necessary for the palliation of pain and symptoms associated with the terminal illness . The ADM stated there was no signature from [Name of Hospice Agency] authorized representative. The ADM stated the hospice agreement must be signed by both parties prior to initiating hospice services for Resident 14. The ADM stated, without the signature the hospice agreement was not valid. The ADM stated he [ADM] was responsible in ensuring contracts with outside service providers, including hospice, were reviewed and signed prior to initiating care or service and it was not done. During a review of Resident 8's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/7/25, the AR indicated, Resident 8 was admitted from an acute care hospital on 1/9/25 to the facility, with diagnoses that included Congestive Heart Failure (CHF- define), Type 2 Diabetes Mellitus (abnormal levels of blood sugar), Hypertension (high blood pressure), and Pleural Effusion (an abnormal accumulation of fluid in the lungs and the chest wall). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Order Summary Report (OSR), dated 3/7/25, the OSR indicated, . Order Summary . Admit to [Name of Nursing Home] for long term placement, with [Name of Hospice Agency] under the care of [Attending Physician] diagnosis of Congestive Heart Failure Order Date . 1/9/25 . During a review of Resident 14's AR, dated 3/13/24, the AR indicated, Resident 14 was admitted from an acute care hospital on 10/4/22 to the facility, with diagnoses which included Alzheimer ' s Disease (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Type 2 Diabetes Mellitus, Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Hypertension, and Anxiety Disorder (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness). During a review of Resident 14's OSR, dated 3/13/25, the OSR indicated, . Admit to [Name of Hospice Agency] with a primary diagnosis of Alzheimer Disease under the care of [Attending Physician] . Order Date . 6/22/23 . During a review of the facility's P&P titled, Hospice Program dated 7/23, the P&P indicated, . Hospice services are available to residents at the end of life . 5. Hospice providers who contract with this facility: a. musth have a written agreement with the facility outlining (in detail) the responsibilities of the facility and the hospice agency . 6. The agreement with the hospice provider will be signed by the facility representative and a representative from the hospice agency before hospice services are furnished to any resident .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 42123 Based on interview and record review, the facility failed to identify, develop and implement an effective Quality Assurance and Performance Improvement (QAPI- a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving) program when the facility did not establish an effective fall prevention program and there were 63 resident falls between 1/1/25 and 3/4/25. This failure resulted in three resident falls (Residents 1, 2 and 6) with significant injury requiring transportation to the acute care hospital for treatment and placed other residents at risk for falls with significant injury and had the potential to affect the quality of care, quality of life, services and safety of the facility's residents. (Cross reference F835, F689) Findings: During a review of the facility ' s document titled Incidents By Incident Type, dated 1/1/25 to 3/4/25, the document indicated, . Total ' Fall ' Incidents: 64 . One fall was crossed out in error. During an interview on 2/12/25 at 4:01 p.m. with the Director of Staff Development (DSD), the DSD stated she was aware the facility had a high number of resident falls. The DSD stated she held a fall prevention in-service for the staff on 1/28/25 to address the high fall rate. The DSD stated she did not test the staff ' s competency after the in-service. During a concurrent interview and record review on 2/12/25 at 4:17 p.m. with the ADM, the ADM stated the QAPI committee included himself, the department heads, the interdisciplinary team (IDT-involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident), and the medical director. The ADM stated the QAPI met on a monthly basis to discuss any issues happening within the facility. The facility ' s document titled Incidents By Incident Type, dated 1/1/25 to 2/12/25 was reviewed. The document indicated there were 31 falls in 1/2025 and 11 falls between 2/1/25-2/12/25. The ADM stated he was aware there were issues with the number of resident falls. The ADM stated the falls were a clinical issue and would fall under the Director of Nursing ' s (DON) responsibility. The ADM reviewed the QAPI document titled [name of facility] Performance Improvement Plan, the plan indicated, . 1. Resident Falls . 2. 4 P ' s [pain, position, placement and personal needs] Fall prevention program (May 2023) . 1. Initiate Safety Committee for Resident Falls which will include Admin [administrator], DON, DOR [Director of Rehabilitation], ACT [activities], RNA [Restorative Nursing Assistant], and DSD [Director of Staff Development] to review and assess resident falls. Committee will review conditions, medications, interventions, as well as hold weekly meetings to identify whether the interventions that have been implemented are affective [effective] and provide new recommendations to reduce resident falls .1. Our goal is to reduce falls to 15 or less per month for three months . There were 31 resident falls in January 2025, the ADM stated he could not answer if the QAPI was effective because he needed to review the month-to-month data. The ADM was unable to state how the data gathered as part of QAPI was used to decrease resident falls. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 2/19/25 at 3:57 p.m. with the ADM, the ADM stated the facility did not have integrated QAPI minutes because each department head took their own minutes and presented the previous months for review. The ADM was unable to provide documentation of the minutes related to the resident falls. The ADM stated the clinical staff was responsible to review and evaluate the falls. The ADM stated he did not know how the clinical staff decided what interventions to put into place for fall prevention, but falls were clinical issues, and it was ultimately the DON ' s responsibility to provide oversight. The ADM stated falls were reviewed during the daily stand-up meeting, but he did not attend it was for clinical staff. The ADM was unable to state what fall performance improvement plan was put into place by the QAPI committee. During an interview on 3/5/25 at 2:37 p.m. with the ADM, the ADM stated resident falls were discussed between clinical staff in the IDT. The ADM stated, There is a lot that goes on in this building. The ADM stated the Director of Nursing was in charge of resident falls and the IDT. The ADM stated, I am not a nurse, so I am not involved in that part, [the] clinical part of the meeting. During a review of the facility ' s policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) Program, dated 2/2020, the P&P indicated, . facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents . objectives of QAPI program are to . provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators . establish systems through which to monitor and evaluate corrective actions . administrator is responsible for assuring that this facility ' s QAPI program complies with federal, state, and local regulatory agency requirements . QAPI committee reports directly to the administrator . QAPI plan describes the process for identifying and correcting quality deficiencies. Key components . tracking and measuring performance . identifying and prioritizing quality deficiencies . systematically analyzing underlying causes of systemic quality deficiencies . developing and implementing corrective action or performance improvement activities . committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments .

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44899 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when one of 12 sampled residents' (Resident 8) oxygen concentrator filter was found covered with dust and lint. This failure placed Resident 8 at an increased risk to develop respiratory and healthcare-associated infections. Findings: During a review of Resident 8's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/7/25, the AR indicated, Resident 8 was admitted from an acute care hospital on 1/9/25 to the facility, with diagnoses that included Congestive Heart Failure (CHF- define), Type 2 Diabetes Mellitus (abnormal levels of blood sugar), Hypertension (high blood pressure), and Pleural Effusion (an abnormal accumulation of fluid in the lungs and the chest wall). During a review of Resident 8's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 1/15/25, the MDS indicated Resident 8's Brief Interview for Mental Status (BIMS) score was 5 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact). During a review of Resident 8's Order Summary Report (OSR), dated 3/7/25, the OSR indicated, . Order Summary . Oxygen at 2-4 liter/minute (unit of measurement) via Nasal Cannula (a device used to deliver supplemental oxygen) related to CHF. May titrate (adjust) level every shift . During a concurrent observation and interview, on 3/6/25, at 4:22 p.m., in Resident 8 ' s room, with the Assistant Director of Nursing (ADON), the ADON looked at Resident 8 ' s oxygen concentrator and stated the oxygen concentrator filter was covered with dust and lint. The ADON stated using a dirty oxygen concentrator was not acceptable. RN 1 stated Resident 8's was not getting the full benefit of supplemental oxygen and her respiratory condition could worsen. The ADON stated maintaining the cleanliness of an oxygen concentrator was the responsibility of the licensed nurses. During an interview on 3/7/25, at 3:21 p.m., with the Director of Nursing (DON), the DON stated using a dirty oxygen concentrator was not acceptable and could potentially cause residents to become ill. The DON stated the purpose of the oxygen concentrator was to improve resident's oxygen level. The DON stated residents using a dirty oxygen concentrator could have respiratory infection. The DON stated she expects the oxygen concentrator to be cleaned weekly and as needed by the licensed nurses for the safety and well-being of all residents receiving oxygen. During a review of the facility ' s document titled, Job Description: Floor Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring equipment is in good operating order . Following Infection and Control policies . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	03/07/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Oxygen Administration, dated 2/24, the P&P stated, . Preparation . 3. Assemble the equipment and supplies as needed . Steps in the Procedure . Check the mask, tank, humidifier, etc., to be sure they are in good working order and are securely fastened . During a review of the facility's policy and procedure (P&P) titled, Assistive Device and Equipment, dated 1/20, the P&P stated, . 6 . c. Device Condition - devices and equipment are maintained on schedule and according to manufacturer ' s instructions. Defective or worn devices are discarded or repaired . During a review of the facility's policy and procedure (P&P) titled, Infection Control, dated 10/18, the P&P indicated, . 1. The facility ' s infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment . 4. All personnel will be trained on our infection control policies and practices . During a review of the oxygen concentrator manual titled, [Brand X] Oxygen Concentrator User Manual, dated 2021, the manual indicated, . Frequency of inspection and cleaning of filter may be dependent upon environmental conditions like dust and lint . NOTE- The air filter should be monitored closely in environments with abnormal amounts of dust and lint .