STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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 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** 45537 Based on observation, interview and record review, the facility failed to ensure one of six sampled resident ' s (Resident 2) care plans were revised after Resident 2 fell on [DATE], and 7/14/2024. This deficient practice resulted in Resident 2 ' s continued falls and subsequent skin tear and discoloration to the left temporal (the area behind the temples and ears) area of her head following a third fall on 11/15/2024. Findings: During a review of Resident 2 ' s Admission Record (Face sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis including metabolic encephalopathy (a condition of the brain that can causes confusion, memory loss or loss of consciousness), unspecified dementia (a condition of loss of mental functioning such as thinking, remembering and reasoning that interferes with a person ' s daily life and activities) and end stage renal disease ([ESRD] a condition in which the kidneys stop working and are not able to remove wastes and extra water from the body). During a review of Resident 2 ' s Minimum Data Set ([MDS] a resident assessment tool dated 4/15/2024, the MDS indicated Resident 2 ' s cognition (a problem with a person ' s ability to think, learn, remember, use judgement, and make decisions) was severely impaired, she required a two person assist to complete her activities of daily living ([ADL] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and a one person assist for repositioning in bed and transfers from chair to bed, bed to chair, and walking. During a review of Resident 2 ' s Care Plan, dated 1/10/2024, the Care Plan indicated Resident 2 was at risk for falls due to poor safety awareness, unsteady gait, balance problem, poor endurance and getting out of bed without calling for assistance. The Care Plan ' s goal was for Resident 2 to be free from injuries related to falls with interventions that included conducting resident rounds/checks on Resident 2 every two hours and as needed, remind Resident 2 to call for assistance, provide cueing and supervision as needed and reinforce safety awareness. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 2 ' s SBAR ([Situation, Background, Assessment, Recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) and Change of Condition (COC) Charting and Skilled Documentation dated 2/11/2024 and timed at 12 p.m., the SBAR and COC indicated Resident 2 had discoloration and pain (pain level not specified) on her right shoulder. The SBAR and COC indicated Resident 2 ' s physician ordered a stat (a medical term that means now or immediately) Xray (a procedure that takes pictures of the areas inside the body) of Resident 2 ' s right shoulder. During a review of Resident 2 ' s Xray, dated 2/11/2024, the Xray indicated Resident 2 had a questionable fracture (a complete or partial break in a bone) of the right scapula (shoulder). During a review of Resident 2 ' s SBAR dated 2/12/2024 at 12:25 p.m., (following the DON ' s investigation of the injury to Resident 2 ' s shoulder discovered on 2/11/2024) the SBAR indicated Resident 2 had a witnessed fall in her room on 2/10/2024 at 10:35 p.m. During a review of a subsequent Xray done on 2/12/2024, the Xray indicated Resident 2 had osteopenia (a condition that occurs when the bone has lost its density [thickness] which can make them weaker and increase the risk of bone fractures) but no fracture of her shoulder. During a review of Resident 2 ' s Morse Fall Risk assessment dated [DATE] at 11:03 a.m., the Morse Fall Risk Assessment indicated Resident 2 was assessed as high risk for falls with a score of 55 (a score of 45 and higher means Hi risk for fall). During a review of Resident 2 ' s clinical record, the clinical record indicated there was no revision to Resident 2 ' s care plan following her fall on 2/10/2024. 2. During a review of Resident 2 ' s SBAR dated 7/14/2024 at 5:23 p.m., the SBAR indicated Resident 2 had an unwitnessed fall inside her room and was found in a sitting position on the floor in front of her wheelchair. The SBAR indicated Resident 2 had a pain level of four (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) to her left buttock. The SBAR indicated Resident 2 was up in her wheelchair thirty minutes before a nursing staff found her sitting in front of her wheelchair in her room. The SBAR indicated Resident 2 was assessed to be high risk for falls with a score of 75 (a score of 45 and higher means Hi risk for falls). During a review of Resident 2 ' s Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help residents achieve their goals) Falls Progress Notes dated 7/15/2024 and timed at 9:18 a.m., the IDT Falls Progress Notes indicated Resident 2 complained of pain following an unwitnessed fall on 7/14/2024 at 5:23 p.m. when Resident 2 tried to get up from a chair without assistance. The IDT Falls Progress Notes indicated Resident 2 had impaired cognition, poor safety awareness and a gait/balance deficit and the facility ' s current safety/preventive measures were to anticipate and meet Resident 2 ' s needs, place Resident 2 ' s bed at lowest position and to check on Resident 2 regularly. The IDT Falls Progress Notes indicated the new/revised safety interventions for Resident 2 was for the facility staff to increase visual checks, encourage Resident 2 to ask for assistance and to closely monitor Resident 2. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 2 ' s SBAR dated 11/15/2025 and timed at 12:50 p.m., the SBAR indicated Resident 2 had an unwitnessed fall inside her room ' s bathroom and was found by a nursing staff sitting next to the toilet. The SBAR indicated Resident 2 sustained a skin tear and discoloration to the left temporal area of her head. During a review of Resident 2 ' s clinical record, the clinical record indicated there was no revision to Resident 2 ' s care plan following her unwitnessed fall on 11/15/2024. During an interview and record review on 1/2/2025 at 6:51 p.m., the Director of Nursing (DON) stated and confirmed Resident 2 ' s care plan interventions on fall precautions have not been revised. The DON confirmed during IDT meetings on 7/15/2024 and 11/18/2024 it was decided to increase visual checks and conduct close monitoring of Resident 2 due to Resident 2 ' s occasional bouts of confusion/ forgetfulness and attempts to perform tasks by herself which were beyond her capabilities. The DON stated the nursing staff take turns monitoring Resident 2 and conducting hourly visual checks, however, there was no documentation of those efforts. The DON stated Resident 2 ' s care plan ' s interventions should have been revised and updated based on Resident 2 ' s COC, fall risk assessments and IDT meetings to ensure appropriate care was provided to prevent Resident 2 from continued falls. During a review of the facility ' s Policies and Procedures (P/P) titled, Care Plans, Comprehensive Person-Centered revised 3/2022, the P/P indicated the facility provides a comprehensive and person-centered care plan to meet the residents ' physical, psychosocial and functional needs and must be developed and implemented for each resident. The P/P indicated the facility ' s interdisciplinary team (IDT) in conjunction with the resident and his/her responsible party must develop and implement the comprehensive, person centered care plan and should reflect the recognized standard of practice for the resident ' s problem areas and conditions, the resident ' s stated goals, strengths, problem areas and conditions and the care plan interventions chosen based on careful consideration of the resident ' s problem areas and their causes. The P/P indicated the assessments of the residents are ongoing and the care plan are revised based on the information of the resident and their changes of condition. During a review of the facility ' s P/P titled, Falls and Fall Risk, Managing revised 3/ 2022, the P/P indicated the facility must identify interventions related to the resident ' s specific risks and causes, based on previous evaluation and current data, to prevent the resident from falling and to minimize complications from falling. The P/P indicated the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors or falls for each resident at risk or with history of falls.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on observation, interview and record review, the facility failed to ensure two of six sampled residents (Resident 1 and Resident 5) were provided incontinence care in a timely manner. This deficient practice resulted in Residents 1 and 5 sitting in a wet and soiled diaper for 55 minutes after they requested assistance and this deficient practice had the potential to cause break down in Resident 1 and 5 ' s skin and cause them to feel uncomfortable, undignified and embarrassed. Findings: a. During a review of Resident 1 ' s Admission Record (Face sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included a cerebral infarction ([stroke] a serious condition that occurs when the blood flow to the brain is blocked, causing the brain tissue to and hypertension ([HTN]. During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 12/20/2024, the MDS indicated Resident 1 was able to make decisions that were consistent and reasonable, and he required a one to two person assist to complete his activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Care Plan, dated 8/6/2024, the Care Plan indicated Resident 1 was at risk for ADL decline and needed assistance to complete his ADLs because of weakness to his left lower extremities due to a stroke, transient ischemic attack (a condition of brief period when blood flow to the brain is blocked causing stroke-like symptoms) and HTN. The Care Plan ' s goal was for Resident 1 to improve his current level of function with interventions including providing good peri care (cleaning and maintenance of the genitals and anal areas of the body) after each incontinence by using soap and water and to provide Resident 1 with dignity and privacy. On 12/31/2024 at 4:19 p.m., Resident 1 observed in his room in bed, he showed Certified Nursing Assistant 1 (CNA 1) a soiled white towel with a yellow colored substance on it and told CNA 1 that he needed to be changed. CNA 1 stated she would get the supplies for incontinence care. During an interview on 12/31/2024 at 4:55 p.m., Resident 1 stated at 4:19 p.m. he told CNA 1 that he needed to be changed. Resident 1 stated, it did not bother him to wait a while but he did not want to be unclean and left in a soiled diaper for a long time because it made him uncomfortable. At 4:58 p.m. Resident 1 pressed his call light button for assistance. Staff answered Resident 1 ' s call light and informed Resident 1 he would look for his nurse. At 5:14 p.m., (55 minutes after Resident 1 asked CNA 1 to change him) CNA 1 came back with supplies and provided incontinence care to Resident 1. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 5 ' s Admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including benign prostatic hyperplasia ([BPH] a non-cancerous condition when the prostate has become enlarged or swollen), generalized weakness, a below the knee amputation ([BKA] a surgical procedure done when the lower leg is removed below the knee joint), and HTN. During a review of Resident 5 ' s MDS dated [DATE], the MDS indicated Resident 5 was able to make decisions that were consistent and reasonable, and required a one person assist to complete his ADLs. During a review of Resident 5 ' s Care Plan dated 12/13/2024, the Care Plan indicated Resident 5 was at risk for ADL decline and needed assistance to complete his ADLs due to HTN, a BKA, and after a fall incident. The Care Plan ' s goal was for Resident 5 to improve his current level of function with interventions to assist Resident 5 as needed while promoting his privacy and dignity. During an observation on 12/31/2024, at 4:20 p.m., Resident 5 was seen and heard telling CNA 2 that incontinence brief needed to be checked to see if it needed changing, CNA 2 told Resident 5 she would come back. During an interview on 12/31/2024 at 5:05 p.m., Resident 5 stated his roommate (Resident 1) had been waiting since 4 p.m., for the nurse to change him and he had been waiting for a while as well. Resident 5 stated he felt undignified to sit on his waste. During an observation on 12/31/2024 at 5:12 p.m. CNA 2 entered Resident 5 ' s room and informed Resident 5 that she would change him later because the dinner trays were about to be passed. Resident 5 told CNA 2, he could not wait and needed to be changed immediately because he wanted to smoke after dinner. CNA 2 informed Resident 5 that she would come back with supplies to change him. At 5:14 p.m., (55 minutes after Resident 5 asked that he be changed) CNA 2 came back with care supplies and provided incontinence care to Resident 5. During an interview on 12/31/2024 at 5:26 p.m., CNA 2 stated Resident 1 could use the urinal but needed to be changed at times because he had periods of incontinence. CNA 2 stated Resident 5 used an incontinence brief today because he was felt tired and was too weak to go to the bathroom. CNA 2 stated she was told during facility orientation that she could not provide an incontinence care to residents while the residents were eating because it was not sanitary. CNA 2 did acknowledge that the dinner trays had not yet been served when the residents were asking to be changed. CNA 2 stated the residents should not be left soiled for an extended period of time because it being wet could cause the residents skin issue and make them feel uncomfortable. During an interview on 12/31/2024 at 5:48 p.m., CNA 1 stated she was working closely with CNA 2 and both were aware that Resident 1 and Resident 5 needed to be assisted with incontinence care. CNA 1 stated the residents had the right to be clean in a timely manner and not doing so could cause the residents to feel frustrated, uncomfortable and undignified. During an interview on 12/31/2024 at 5:54 p.m., Licensed Vocational Nurse 1 (LVN 1) stated the residents should be assisted with their ADL care as soon as possible to prevent complications of skin breakdown and urinary tract infection ([UTI] an infection in which bacteria invade the urinary tract), and to ensure the residents were comfortable. (continued on next page)

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The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/31/2024 at 6:03 p.m., Registered Nurse Supervisor 1 (RNS 1) stated it was the responsibility of the nursing staff to work as a team to ensure the needs of the residents are met and provided in a timely manner. During an interview on 12/31/2024 at 6:12 p.m., the Director of Nursing (DON) stated the nursing staff are expected to anticipate and provide the residents with ADL care in a timely manner to prevent skin breakdown. During a review of the facility ' s Policies and Procedures (P/P) titled, Activities of Daily Living (ADL), Supporting revised 3/2022, the P/P indicated the facility will provide the residents with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living such as hygiene, mobility, elimination, dining and communication. The P/P indicated the facility will provide appropriate assistance and support to the residents based on their plan of care and interventions, identified through the residents ' assessments, preferences, stated goals and standards of practice. During a review of the facility ' s P/P titled, Dignity revised 2/2012, the P/P indicated each resident of the facility shall be cared for in a manner that promotes and enhances his/her sense of well-being, level of satisfaction in life, and feelings of self-worth and self-esteem by honoring their needs and preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45537 Based on interview and record review, the facility failed to ensure one of six sampled resident ' s (Resident 2) did not fall an sustain an injury when her care plans were revised after Resident 2 ' s falls on 2/10/2024, and 7/14/2024. This deficient practice resulted in Resident 2 sustaining a skin tear and discoloration to the left temporal (the area behind the temples and ears) area of her head following a third fall on 11/15/2024. Findings: During a review of Resident 2 ' s Admission Record (Face sheet), the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis including metabolic encephalopathy (a condition of the brain that can causes confusion, memory loss or loss of consciousness), unspecified dementia (a condition of loss of mental functioning such as thinking, remembering and reasoning that interferes with a person ' s daily life and activities) and end stage renal disease ([ESRD] a condition in which the kidneys stop working and are not able to remove wastes and extra water from the body). During a review of Resident 2 ' s Minimum Data Set ([MDS] a resident assessment tool dated 4/15/2024, the MDS indicated Resident 2 ' s cognition (a problem with a person ' s ability to think, learn, remember, use judgement, and make decisions) was severely impaired, she required a two person assist to complete her activities of daily living ([ADL] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and a one person assist for repositioning in bed and transfers from chair to bed, bed to chair, and walking. During a review of Resident 2 ' s Care Plan, dated 1/10/2024, the Care Plan indicated Resident 2 was at risk for falls due to poor safety awareness, unsteady gait, balance problem, poor endurance and getting out of bed without calling for assistance. The Care Plan ' s goal was for Resident 2 to be free from injuries related to falls with interventions that included conducting resident rounds/checks on Resident 2 every two hours and as needed, remind Resident 2 to call for assistance, provide cueing and supervision as needed and reinforce safety awareness. 1. During a review of Resident 2 ' s SBAR ([Situation, Background, Assessment, Recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) and Change of Condition (COC) Charting and Skilled Documentation dated 2/11/2024 and timed at 12 p.m., the SBAR and COC indicated Resident 2 had discoloration and pain (pain level not specified) on her right shoulder. The SBAR and COC indicated Resident 2 ' s physician ordered a stat (a medical term that means now or immediately) Xray (a procedure that takes pictures of the areas inside the body) of Resident 2 ' s right shoulder. During a review of Resident 2 ' s Xray, dated 2/11/2024, the Xray indicated Resident 2 had a questionable fracture (a complete or partial break in a bone) of the right scapula (shoulder). (continued on next page)

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The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s SBAR dated 2/12/2024 at 12:25 p.m., (following the DON ' s investigation of the injury to Resident 2 ' s shoulder discovered on 2/11/2024) the SBAR indicated Resident 2 had a witnessed fall in her room on 2/10/2024 at 10:35 p.m. During a review of a subsequent Xray done on 2/12/2024, the Xray indicated Resident 2 had osteopenia (a condition that occurs when the bone has lost its density [thickness] which can make them weaker and increase the risk of bone fractures) but no fracture of her shoulder. During a review of Resident 2 ' s Morse Fall Risk assessment dated [DATE] at 11:03 a.m., the Morse Fall Risk Assessment indicated Resident 2 was assessed as high risk for falls with a score of 55 (a score of 45 and higher means Hi risk for fall). During a review of Resident 2 ' s clinical record, the clinical record indicated there was no revision to Resident 2 ' s care plan following her fall on 2/10/2024. 2. During a review of Resident 2 ' s SBAR dated 7/14/2024 at 5:23 p.m., the SBAR indicated Resident 2 had an unwitnessed fall inside her room and was found in a sitting position on the floor in front of her wheelchair. The SBAR indicated Resident 2 had a pain level of four (an 11 eleven point scale where pain is rated from zero to 10; 0=no pain, 1-3=mild pain, 4-6=moderate pain, and 7-10=severe pain, and 10=worst imaginable pain) to her left buttock. The SBAR indicated Resident 2 was up in her wheelchair thirty minutes before a nursing staff found her sitting in front of her wheelchair in her room. The SBAR indicated Resident 2 was assessed to be high risk for falls with a score of 75 (a score of 45 and higher means Hi risk for falls). During a review of Resident 2 ' s Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help residents achieve their goals) Falls Progress Notes dated 7/15/2024 and timed at 9:18 a.m., the IDT Falls Progress Notes indicated Resident 2 complained of pain following an unwitnessed fall on 7/14/2024 at 5:23 p.m. when Resident 2 tried to get up from a chair without assistance. The IDT Falls Progress Notes indicated Resident 2 had impaired cognition, poor safety awareness and a gait/balance deficit and the facility ' s current safety/preventive measures were to anticipate and meet Resident 2 ' s needs, place Resident 2 ' s bed at lowest position and to check on Resident 2 regularly. The IDT Falls Progress Notes indicated the new/revised safety interventions for Resident 2 was for the facility staff to increase visual checks, encourage Resident 2 to ask for assistance and to closely monitor Resident 2. 3. During a review of Resident 2 ' s SBAR dated 11/15/2025 and timed at 12:50 p.m., the SBAR indicated Resident 2 had an unwitnessed fall inside her room ' s bathroom and was found by a nursing staff sitting next to the toilet. The SBAR indicated Resident 2 sustained a skin tear and discoloration to the left temporal area of her head. During a review of Resident 2 ' s clinical record, the clinical record indicated there was no revision to Resident 2 ' s care plan following her unwitnessed fall on 11/15/2024. During an interview on 1/2/2025 at 12:34 p.m., Restorative Nursing Assistant 1 (RNA 1) stated Resident 2 needed constant cueing, a front wheel walker ([FWW] an aid that provides stability and balance while walking) to assist her to walk and one person to assist her with ambulation. RNA 1 stated Resident 2 had a slow and unsteady gait and was forgetful and was at risk for falls. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/2/2025 at 6 p.m., the Director of Rehabilitation Services (DORS) stated during the Interdisciplinary Meetings for Resident 2 that were conducted on 7/15/2024 and 11/18/2024, it was decided that Resident 2 ' s visual checks and close monitoring should increase because Resident 2 had occasional bouts of confusion, impulsivity (the tendency to act without thinking), and attempts to perform tasks that were beyond her capabilities. During an interview and record review on 1/2/2025 at 6:51 p.m., the Director of Nursing (DON) stated and confirmed Resident 2 ' s care plan interventions on fall precautions have not been revised. The DON confirmed during IDT meetings on 7/15/2024 and 11/18/2024 it was decided to increase visual checks and conduct close monitoring of Resident 2 due to Resident 2 ' s occasional bouts of confusion/ forgetfulness and attempts to perform tasks by herself which were beyond her capabilities. The DON stated the nursing staff take turns monitoring Resident 2 and conducting hourly visual checks, however, there was no documentation of those efforts. The DON stated Resident 2 had three fall incidents in the facility because Resident 2 was not able to fully understand the staff instructions on safety precautions and Resident 2 tried to perform tasks beyond her capabilities. The DON stated Resident 2 ' s care plan ' s interventions should have been revised and updated based on Resident 2 ' s COC, fall risk assessments and IDT meetings to ensure appropriate care was provided to prevent Resident 2 from continued falls which could harm Resident 2. During a review of the facility ' s Policies and Procedures (P/P) titled, Falls and Fall Risk, Managing revised 3/ 2022, the P/P indicated the facility must identify interventions related to the resident ' s specific risks and causes, based on previous evaluation and current data, to prevent the resident from falling and to minimize complications from falling. The P/P indicated the staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors or falls for each resident at risk or with history of falls. During a review of the facility ' s P/P titled, Safety and Supervision of Residents revised 7/2022, the P/P indicated the facility shall strive to supervise and attend to the residents to ensure their safety. The P/P indicated the facility, and its IDT will perform assessments and observations to identify any specific risk for individual residents and shall provide individualized, resident- centered approach to safety for each resident ensuring the interventions are implemented correctly and consistently, evaluated for its effectiveness and modified/ replaced as needed.