STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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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 - Few	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 one of three sampled residents (Resident 1) when Resident 1 was assessed as being a high fall risk with poor safety awareness 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 falls on 3/15/25 and 3/16/25 sustaining a fracture of the left greater trochanter (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis) causing pain and decreased mobility which required transportation to the emergency department (ED) for assessment and treatment of his injury. Resident 1 had a third fall on 3/17/25 which placed the resident at risk for further serious injury. (Cross reference F689) Findings: During a review of Resident 1 ' s CT scan (CT-medical imaging that uses X-rays [uses a type of radiation to create images inside the body] and computers to create detailed images of the body) results from the acute care hospital (ACH), dated 3/17/25, the CT results indicated, . Acute comminuted fracture [type of fracture where the bone breaks into three or more pieces] of the greater trochanter of the left femur with minimum displacement [broken ends of bone are relatively aligned] . 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 hemiplegia (weakness or paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is disrupted), palliative care (specialized medical care focused on relieving symptoms of a serious illness), squamous cell carcinoma of skin (type of skin cancer), Type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), transient cerebral ischemic attack (temporary interruption of blood flow to the brain) and spinal stenosis (condition where the spinal canal becomes narrowed). (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 11 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 11 ' s cognition was moderately impaired. During a concurrent observation and interview on 4/1/25 at 9:30 a.m., with Resident 1, Resident 1 was lying in bed, dressed and groomed. There was a wheelchair and four-wheeled walker observed near his bed. Resident 1 complained of pain to bilateral hips and stated he had fallen, and his left hip was swollen and painful. Resident 1 stated he fell about a week ago (on 3/15/25) when he rushed to the bathroom without an assistive device and the resident from the adjoining room pushed the bathroom door open hitting him in the head and causing him to fall on the ground. Resident 1 stated he was hit on his forehead, back of his head on the left side and landed on his left hip. Resident 1 stated, It hurt really bad. Resident 1 stated he had a portable X-ray done at the facility which did not show any fractures but was sent to the emergency room the next day where he was told he had a hip fracture. Resident 1 stated the fracture was not severe enough to require surgery, so he was sent from the ED back to the facility. Resident 1 stated he was independent to go to the bathroom and back, so he did not use his call light or walker. During an interview on 4/1/25 at 9:41 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 would not use his call light to call for help. CNA 1 stated Resident 1 would take himself to the bathroom without assistance. During an interview on 4/1/25 at 10:12 a.m. with CNA 2, CNA 2 stated Resident 1 would get out of bed and walk to the bathroom independently. CNA 2 stated Resident 1 used the call light when he needed pain medication but otherwise did not call for help. CNA 2 stated Resident 2 would hold onto items to walk to the bathroom such as the bedside table, footboard and walls to get to the bathroom. CNA 2 stated Resident 1 needed to have supervision and use his walker to ambulate safely. During a review of Resident 1 ' s fall care plan, dated 3/16/25, the care plan indicated, . unwitnessed fall on 3/15/25 and 3/16/25 . be free of complications r/t [related to] unwitnessed fall . Assess pain . Educate [Resident 1] to utilize call light and to wait for assistance . Medication adjustment/review . Notify MD for any significant changes . X-ray to hip bilateral with pelvis . During a review of Resident 1 ' s fall care plan dated 3/17/25, the care plan indicated, . witnessed fall 3/17/25, no injury . will not have any delayed trauma . Monitor for any s/s [signs/symptoms] delayed trauma . Q [every] shift monitoring . Refer to [Name of Behavioral Health] . (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 - Few	During a review of Resident 1 ' s 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, dated 3/17/25, the IDT note indicated, . IDT meeting due to s/p [status post] 2 unwitnessed falls 03/15 and 03/16 [2025] . Fall #1 03/15/25 . Observation/Evaluation (LVN) . heard a commotion from resident ' s room . find resident lying on his back in the space between him and his roommate ' s bed . Resident was noted to have a slightly discolored area to the right side of his forehead as well as an abrasion to L hip and ST to L shin . Fall #2 03/16/25 . heard resident calling for help in the room . Found resident lying in supine position in between the bed spaces . Bump on forehead and left hip pain with skin tear to left shin . Left hip in excessive pain . Resident ' s appeared more confused than baseline, story changed multiple times . Root Cause . 1stfall, Resident attempted to ambulate independently to the bathroom, he grabbed knob to bathroom door and when he did, another resident was in the bathroom and pushed the door outward toward resident, causing the door to make contact . which caused him to fall to floor . 2nd fall, Resident attempted to ambulate in his room, went to the closet to get his pains and pulled on pants from hanger and stated, I was blacking out and I fell to the floor . Resident does not use call light or ask for assistance . even after education provided to use call light. Resident has a walker at bedside and refuses to use it with transfers or ambulation . Resident had an X-ray in facility on 03/16 after 1stfall . which resulted NEGATIVE . Resident was sent out to [Name of General Acute Care Hospital] . per resident ' s request and authorization from [Name] Hospice and a CT scan was ordered and resulted: Acute Comminuted fracture of the greater trochanter of the left femur with minimum displacement . During a review of Resident 1 ' s IDT Review, dated 3/18/25, the IDT note indicated, . Resident brought to IDT meeting due to s/p witnessed fall 03/17/25 . Frequent falls . Resident continues to use bathroom unattended despite constant verbal reminders by staff that hes non wt [weight] bearing . Resident interviewed: I just want to prove to myself that I can still do it . ROOT CAUSE: Resident is impulsive, resistant to redirection and does not follow any orders provided. After education provided to resident to not bear weight [act of supporting the weight of something] on left lower extremity [leg], resident got up from his bed and ambulated through his room to the door, causing him to fall to floor . Continue current POC [plan of care]. Refer to [name] Behavioral Health Specialist provided by [name] Hospice. Care Plan reviewed and updated . During a concurrent interview and record review on 4/1/25 at 10:29 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was assigned to Resident 1. LVN 1 stated Resident 1 tended to get up to bathroom and back to bed without supervision. Resident 1 ' s progress notes were reviewed, LVN 1 stated Resident 1 fell on [DATE], 3/16/25 and 3/17/25. Resident 1 ' s fall risk care plans were reviewed. LVN 1 stated Resident 1 would not use the call light and interventions to remind him or educate him to use it were not effective. LVN 1 stated the interventions were basic and would apply to most residents. LVN 1 stated the care plans did not address Resident 1 ' s specific needs, such as his noncompliance with the call light. LVN 1 stated Resident 1 needed more frequent supervision and to be put on a toileting schedule because he frequently ambulated to the bathroom by himself. (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 - Few	During a concurrent interview and record review on 4/1/25 at 11:25 a.m. with the MDS Coordinator (MDSC), Resident 1 ' s care plans were reviewed, the MDSC stated Resident 1 was known to be non-compliant and interventions of encourage call light, call light in reach, educate on risks versus benefits were not effective interventions. The MDSC stated the care plan interventions did not address the root cause of Resident 1 ' s falls which was poor safety awareness, impulsiveness and noncompliance with call light and assistive devices. The MDSC stated Resident 1 ' s care plans were not individualized for Resident 1 ' s needs. During a concurrent interview and record review on 4/1/25 at 12:13 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 had a fall on 3/15/25 when the adjoining neighbor opened the bathroom door as he tried to enter, causing him to hit his head and fall but the resident was not sent to the ED. The ADON stated he had an X-ray of his hip done at the facility with negative results. The ADON stated Resident 1 had an unwitnessed fall on 3/16/25 and was found on the floor by one of the charge nurses in between his bed and his neighbor ' s bed. The ADON stated he complained of pain and the nurse was given the authorization from hospice to send him to the ED. The ADON stated a CT scan was performed in the ED which indicated Resident 1 had a comminuted fracture to his left trochanter and he was sent back to the facility on the morning of 3/17/25. The ADON stated Resident 1 had another fall on 3/17/25 after he was sent back to the facility with orders to be non-weight bearing on his left leg. The ADON stated the resident had ambulated to the doorway behind his wheelchair, turned around and fell on the floor in front of the charge nurse. The ADON stated Resident 1 rarely used his call light to ask for assistance to the bathroom and back. The ADON stated Resident 1 ' s fall risk assessment indicated he was at high risk for falls. Resident 1 ' s care plans were reviewed, the ADON stated the care plan was not updated after the falls on 3/15/25 and 3/16/25 because it happened on the weekend. The ADON stated the IDT met on 3/17/25 and the care plans were updated. The ADON stated care plans were a plan of care individualized to each resident to take care of their own specific needs. The ADON reviewed Resident 1 ' s fall care plan interventions and stated they were not specific and individualized to him and could apply to any resident. The ADON stated Resident 1 continued to fall despite the facility ' s routine two-hour checks for all residents. The ADON stated Resident 1 needed more frequent supervision to prevent his falls. The ADON stated Resident 1 ' s care plan did not address the amount of supervision Resident 1 required for safety. Resident 1 ' s MDS Section GG, was reviewed. The ADON stated the MDS indicated Resident 1 required supervision or touch assistance for toileting and ambulating short distances which meant somebody needed to be with him to go to the bathroom. The ADON stated Resident 1 should a gait belt (a strap worn around a person ' s waist, used by caregivers to assist with walking) on and a walker with him for safety. The ADON stated Resident 1 ' s fall care plans did not address caregivers helping him to the bathroom or use of a gait belt. During an interview and record review on 4/1/25 at 1:21 p.m. with the Director of Nursing (DON), the DON stated she was concerned because Resident 1 had three falls within three days. The DON stated she had discussed Resident 1 ' s falls with his hospice agency because they were also responsible to help prevent falls. Resident 1 ' s IDT notes were reviewed. The DON stated the root cause of Resident 1 ' s falls were his impulsive behaviors, poor safety awareness and non-compliance. The DON reviewed Resident 1 ' s fall care plan and stated the interventions to remind him to use the call light and education were not effective in preventing his falls because of his non-compliance. The DON stated Resident 1 ' s care plan interventions did not address the level of supervision and assistance needed for ADLs (activities of daily living-fundamental self-care tasks to maintain independence and well-being such as bathing, dressing, toileting and mobility) and to prevent falls. The DON stated, we could not do anything to prevent his falling. (continued on next page)

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F 0656 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 Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan . includes measurable objectives and timeframes . 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 . interventions address the underlying source(s) of the problem area(s), not just the symptoms or triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change . interdisciplinary teat reviews and updates the care plan . when there has been a significant change in the resident ' s condition . During a review of the facility ' s policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, . Based on previous evaluations and current data, the 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 . pain . functional impairments . balance and gait disorders . The staff . will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions . staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stop . staff will identify and implement relevant interventions . to try to minimize serious consequences of falling . staff will monitor and document each resident ' s response to interventions intended to reduce falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to reconsider possible causes . 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 one of three sampled residents (Resident 1) when Resident 1 was assessed as being a high fall risk with poor safety awareness 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 falls on 3/15/25 and 3/16/25 sustaining a fracture of the left greater trochanter (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis) causing pain and decreased mobility which required transportation to the emergency department (ED) for assessment and treatment of his injury. Resident 1 had a third fall on 3/17/25 which placed the resident at risk for further serious injury. (Cross reference F689) Findings: During a review of Resident 1 ' s CT scan (CT-medical imaging that uses X-rays [uses a type of radiation to create images inside the body] and computers to create detailed images of the body) results from the acute care hospital (ACH), dated 3/17/25, the CT results indicated, . Acute comminuted fracture [type of fracture where the bone breaks into three or more pieces] of the greater trochanter of the left femur with minimum displacement [broken ends of bone are relatively aligned] . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 hemiplegia (weakness or paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is disrupted), palliative care (specialized medical care focused on relieving symptoms of a serious illness), squamous cell carcinoma of skin (type of skin cancer), Type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), transient cerebral ischemic attack (temporary interruption of blood flow to the brain) and spinal stenosis (condition where the spinal canal becomes narrowed). 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 11 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 11 ' s cognition was moderately impaired. During a concurrent observation and interview on 4/1/25 at 9:30 a.m., with Resident 1, Resident 1 was lying in bed, dressed and groomed. There was a wheelchair and four-wheeled walker observed near his bed. Resident 1 complained of pain to bilateral hips and stated he had fallen, and his left hip was swollen and painful. Resident 1 stated he fell about a week ago (on 3/15/25) when he rushed to the bathroom without an assistive device and the resident from the adjoining room pushed the bathroom door open hitting him in the head and causing him to fall on the ground. Resident 1 stated he was hit on his forehead, back of his head on the left side and landed on his left hip. Resident 1 stated, It hurt really bad. Resident 1 stated he had a portable X-ray done at the facility which did not show any fractures but was sent to the emergency room the next day where he was told he had a hip fracture. Resident 1 stated the fracture was not severe enough to require surgery, so he was sent from the ED back to the facility. Resident 1 stated he was independent to go to the bathroom and back, so he did not use his call light or walker. During an interview on 4/1/25 at 9:41 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 would not use his call light to call for help. CNA 1 stated Resident 1 would take himself to the bathroom without assistance. During an interview on 4/1/25 at 10:12 a.m. with CNA 2, CNA 2 stated Resident 1 would get out of bed and walk to the bathroom independently. CNA 2 stated Resident 1 used the call light when he needed pain medication but otherwise did not call for help. CNA 2 stated Resident 2 would hold onto items to walk to the bathroom such as the bedside table, footboard and walls to get to the bathroom. CNA 2 stated Resident 1 needed to have supervision and use his walker to ambulate safely. During a review of Resident 1 ' s fall care plan, dated 3/16/25, the care plan indicated, . unwitnessed fall on 3/15/25 and 3/16/25 . be free of complications r/t [related to] unwitnessed fall . Assess pain . Educate [Resident 1] to utilize call light and to wait for assistance . Medication adjustment/review . Notify MD for any significant changes . X-ray to hip bilateral with pelvis . During a review of Resident 1 ' s fall care plan dated 3/17/25, the care plan indicated, . witnessed fall 3/17/25, no injury . will not have any delayed trauma . Monitor for any s/s [signs/symptoms] delayed trauma . Q [every] shift monitoring . Refer to [Name of Behavioral Health] . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/1/25 at 11:25 a.m. with the MDS Coordinator (MDSC), Resident 1 ' s care plans were reviewed, the MDSC stated Resident 1 was known to be non-compliant and interventions of encourage call light, call light in reach, educate on risks versus benefits were not effective interventions. The MDSC stated the care plan interventions did not address the root cause of Resident 1 ' s falls which was poor safety awareness, impulsiveness and noncompliance with call light and assistive devices. The MDSC stated Resident 1 ' s care plans were not individualized for Resident 1 ' s needs. During a concurrent interview and record review on 4/1/25 at 12:13 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 had a fall on 3/15/25 when the adjoining neighbor opened the bathroom door as he tried to enter, causing him to hit his head and fall but the resident was not sent to the ED. The ADON stated he had an X-ray of his hip done at the facility with negative results. The ADON stated Resident 1 had an unwitnessed fall on 3/16/25 and was found on the floor by one of the charge nurses in between his bed and his neighbor ' s bed. The ADON stated he complained of pain and the nurse was given the authorization from hospice to send him to the ED. The ADON stated a CT scan was performed in the ED which indicated Resident 1 had a comminuted fracture to his left trochanter and he was sent back to the facility on the morning of 3/17/25. The ADON stated Resident 1 had another fall on 3/17/25 after he was sent back to the facility with orders to be non-weight bearing on his left leg. The ADON stated the resident had ambulated to the doorway behind his wheelchair, turned around and fell on the floor in front of the charge nurse. The ADON stated Resident 1 rarely used his call light to ask for assistance to the bathroom and back. The ADON stated Resident 1 ' s fall risk assessment indicated he was at high risk for falls. Resident 1 ' s care plans were reviewed, the ADON stated the care plan was not updated after the falls on 3/15/25 and 3/16/25 because it happened on the weekend. The ADON stated the IDT met on 3/17/25 and the care plans were updated. The ADON stated care plans were a plan of care individualized to each resident to take care of their own specific needs. The ADON reviewed Resident 1 ' s fall care plan interventions and stated they were not specific and individualized to him and could apply to any resident. The ADON stated Resident 1 continued to fall despite the facility ' s routine two-hour checks for all residents. The ADON stated Resident 1 needed more frequent supervision to prevent his falls. The ADON stated Resident 1 ' s care plan did not address the amount of supervision Resident 1 required for safety. Resident 1 ' s MDS Section GG, was reviewed. The ADON stated the MDS indicated Resident 1 required supervision or touch assistance for toileting and ambulating short distances which meant somebody needed to be with him to go to the bathroom. The ADON stated Resident 1 should a gait belt (a strap worn around a person ' s waist, used by caregivers to assist with walking) on and a walker with him for safety. The ADON stated Resident 1 ' s fall care plans did not address caregivers helping him to the bathroom or use of a gait belt. During an interview and record review on 4/1/25 at 1:21 p.m. with the Director of Nursing (DON), the DON stated she was concerned because Resident 1 had three falls within three days. The DON stated she had discussed Resident 1 ' s falls with his hospice agency because they were also responsible to help prevent falls. Resident 1 ' s IDT notes were reviewed. The DON stated the root cause of Resident 1 ' s falls were his impulsive behaviors, poor safety awareness and non-compliance. The DON reviewed Resident 1 ' s fall care plan and stated the interventions to remind him to use the call light and education were not effective in preventing his falls because of his non-compliance. The DON stated Resident 1 ' s care plan interventions did not address the level of supervision and assistance needed for ADLs (activities of daily living-fundamental self-care tasks to maintain independence and well-being such as bathing, dressing, toileting and mobility) and to prevent falls. The DON stated, we could not do anything to prevent his falling. (continued on next page)

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	055410	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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F 0656 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 Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, . comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident . The comprehensive, person-centered care plan . includes measurable objectives and timeframes . 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 . interventions address the underlying source(s) of the problem area(s), not just the symptoms or triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change . interdisciplinary teat reviews and updates the care plan . when there has been a significant change in the resident ' s condition . During a review of the facility ' s policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, . Based on previous evaluations and current data, the 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 . pain . functional impairments . balance and gait disorders . The staff . will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions . staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stop . staff will identify and implement relevant interventions . to try to minimize serious consequences of falling . staff will monitor and document each resident ' s response to interventions intended to reduce falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to reconsider possible causes .

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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 to prevent falls for one of three sampled residents (Resident 1) when Resident 1 was assessed to be at risk for falls on 1/22/25, had impulsive behavior and staff were aware of Resident 1 not using the call light to request assistance to walk in his room and effective individualized interventions to prevent falls were not implemented. Resident 1 experienced an unwitnessed fall on 3/15/25, fall on 3/16/25 and a fall on 3/17/25. These failures resulted in Resident 1 ' s avoidable fall on 3/16/25 sustaining a fracture of the left greater trochanter (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis) causing pain and decreased mobility which required transportation to the emergency department (ED) for assessment and treatment of his injury and was readmitted to the facility. Resident 1 had a third fall on 3/17/25 which placed the resident at risk for further serious injury. Findings: During a concurrent observation and interview on 4/1/25 at 9:30 a.m., with Resident 1, Resident 1 was lying in bed, dressed and groomed. There was a wheelchair and four-wheeled walker observed near his bed. Resident 1 complained of pain to bilateral hips and stated he had fallen, and his left hip was swollen and painful. Resident 1 stated he fell about a week ago (on 3/15/25) when he rushed to the bathroom without his walker or wheelchair and at the same time, the resident from the adjoining room pushed the bathroom door open hitting him in the head causing him to fall on the ground. Resident 1 stated he was hit on his forehead, back of his head on the left side and landed on his left hip. Resident 1 stated, It hurt really bad. Resident 1 stated he had a portable X-ray done at the facility which did not show any fractures but was sent to the emergency room the next day where he was told he had a hip fracture. Resident 1 stated the fracture was not severe enough to require surgery, so he was sent from the ED back to the facility. Resident 1 stated he was independent to go to the bathroom and back, so he did not use his call light or walker. During a review of Resident 1 ' s CT scan (CT-specialized Xray machine to create detailed images of the body) results from the acute care hospital (ACH), dated 3/17/25, the CT scan results indicated, . Acute comminuted fracture [type of fracture where the bone breaks into three or more pieces] of the greater trochanter of the left femur with minimum displacement [broken ends of bone are relatively aligned] . 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 left sided hemiplegia (weakness or paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is disrupted), palliative care (specialized medical care focused on relieving symptoms of a serious illness), squamous cell carcinoma of skin (type of skin cancer), Type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), transient cerebral ischemic attack (temporary interruption of blood flow to the brain) and spinal stenosis (condition where the spinal canal becomes narrowed). (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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 11 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 11 ' s cognition was moderately impaired. During an interview on 4/1/25 at 9:41 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 would not use his call light to call for help. CNA 1 stated Resident 1 would take himself to the bathroom without assistance. During an interview on 4/1/25 at 10:12 a.m. with CNA 2, CNA 2 stated Resident 1 would get out of bed and walk to the bathroom independently. CNA 2 stated Resident 1 used the call light when he needed pain medication but otherwise did not call for help. CNA 2 stated Resident 2 would hold onto items to walk to the bathroom such as the bedside table, footboard and walls to get to the bathroom. CNA 2 stated Resident 1 needed to have supervision and use his walker to ambulate safely. During a review of Resident 1 ' s fall care plan, dated 3/16/25, the care plan indicated, . unwitnessed fall on 3/15/25 and 3/16/25 . be free of complications r/t [related to] unwitnessed fall . Assess pain . Educate [Resident 1] to utilize call light and to wait for assistance . Medication adjustment/review . Notify MD [Medical Doctor] for any significant changes . X-ray to hip bilateral with pelvis . During a review of Resident 1 ' s fall care plan dated 3/17/25, the care plan indicated, . witnessed fall 3/17/25, no injury . will not have any delayed trauma . Monitor for any s/s [signs/symptoms] delayed trauma . Q [every] shift monitoring . Refer to [Name of Behavioral Health] . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 4/1/25 at 10:29 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was usually assigned to Resident 1. LVN 1 stated Resident 1 tended to get up to the bathroom and back to bed without supervision. Resident 1 ' s progress notes were reviewed, LVN 1 stated Resident 1 fell on [DATE], 3/16/25 and 3/17/25. 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]-Change in Condition, dated 3/15/25, was reviewed. The SBAR indicated, . at 1840 (6:40 p.m.) I heard a commotion from resident ' s room. I entered to find resident lying on his back in the space between him and his roommates bed . Assessment . abras [abrasion-superficial scrape of the skin] on to L [left] hip and ST [skin tear] to L shin . resident stated he was trying to pull open the bathroom door and the resident from adjoining room, who was in the bathroom at that time, pushed the door from the inside striking the resident in the head which caused him to fall and land on back . LVN 1 stated two rooms shared the same bathroom. Resident 1 ' s SBAR-Change in Condition, dated 3/16/25, the SBAR indicated, . nurse heard resident calling for help in the room. Found resident lying in supine [lying face upward] position in between the bed spaces. He said he was getting pants in closet and fell backwards and blacked out for a bit before he became conscious again . Resident had a fall the day before . left hip pain with skin tear to left shin . contusion [bruise] and raised bump on left back of head . left hip in excessive pain . Called hospice [specialized care focused on end of life treatment] at 2120 [9:20 p.m.] to update on resident ' s situation and to tell them resident wants to go to the hospital . Transported on gurney [wheeled stretcher] . Resident 1 ' s SBAR-Change in Condition, dated 3/17/25, the SBAR indicated, . Resident in hallway standing writer immediately saw resident and told him why are you standing up? Resident turned around and fell on floor with arms out stretched . Resident continues to use bathroom unattended despite constant verbal reminders by staff that he ' s [sic] non wt [weight] bearing . no new injuries . I just want to prove to myself I can still do it [walk] . LVN 1 stated Resident 1 would walk from his bed to the bathroom and back by himself. LVN 1 stated Resident 1 would not use the call light and interventions to remind him or educate him to use it were not effective. Resident 1 ' s fall risk care plans were reviewed. LVN 1 stated the interventions were basic and would apply to most residents. LVN 1 stated the care plans did not address Resident 1 ' s specific needs, such as his noncompliance with the call light. LVN 1 stated Resident 1 needed more frequent supervision and to be put on a toileting schedule because he frequently ambulated to the bathroom by himself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1 ' s 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, dated 3/17/25, the IDT note indicated, . IDT meeting due to s/p [status post] 2 unwitnessed falls 03/15 and 03/16 [2025] . Fall #1 03/15/25 . Observation/Evaluation (LVN) . heard a commotion from resident ' s room . find resident lying on his back in the space between him and his roommate ' s bed . Resident was noted to have a slightly discolored area to the right side of his forehead as well as an abrasion to L hip and ST to L shin . Fall #2 03/16/25 . heard resident calling for help in the room . Found resident lying in supine position in between the bed spaces . Bump on forehead and left hip pain with skin tear to left shin . Left hip in excessive pain . Resident ' s appeared more confused than baseline, story changed multiple times . Root Cause . 1st fall, Resident attempted to ambulate independently to the bathroom, he grabbed knob to bathroom door and when he did, another resident was in the bathroom and pushed the door outward toward resident, causing the door to make contact . which caused him to fall to floor . 2nd fall, Resident attempted to ambulate in his room, went to the closet to get his pants and pulled on pants from hanger and stated, I was blacking out and I fell to the floor . Resident does not use call light or ask for assistance . even after education provided to use call light. Resident has a walker at bedside and refuses to use it with transfers or ambulation [act of walking] . Resident had an X-ray in facility on 03/16 after 1st fall . which resulted NEGATIVE . Resident was sent out to [name of acute Emergency Department] per resident ' s request and authorization from [Name] Hospice and a CT scan was ordered and resulted: Acute Comminuted fracture of the greater trochanter of the left femur with minimum displacement . During a review of Resident 1 ' s IDT Review, dated 3/18/25, the IDT note indicated, . Resident brought to IDT meeting due to s/p witnessed fall 03/17/25 . Frequent falls . Resident continues to use bathroom unattended despite constant verbal reminders by staff that he ' s non wt [weight] bearing . Resident interviewed: I just want to prove to myself that I can still do it . ROOT CAUSE: Resident is impulsive, resistant to redirection and does not follow any orders provided. After education provided to resident to not bear weight [act of supporting the weight of something] on left lower extremity [leg], resident got up from his bed and ambulated through his room to the door, causing him to fall to floor . Continue current POC [plan of care]. Refer to [name] Behavioral Health Specialist provided by [name] Hospice. Care Plan reviewed and updated . During a review of Resident 1 ' s Risk For Falls, dated 1/22/25, the fall risk indicated Resident 1 ' s score was 10 which placed him in the High fall risk category. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 4/1/25 at 11:25 a.m. with the MDS Coordinator (MDSC), Resident 1 ' s MDS Assessment, Section GG-Functional Abilities, dated 2/11/25, was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 04 [Supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance)] . D. sit to stand . code 04 . F. Toilet transfer . code 04 . Walk 10 feet . code 04 . The MDSC stated Resident 1 should have a CNA standing there watching him, ready to assist as needed when ambulating, including to the bathroom and back to bed. The MDSC stated Resident 1 was known to be a high fall risk, non-compliant and did not use his call light to call for assistance. Resident 1 ' s fall risk care plan dated 3/14/24, the care plan indicated, . resident is at risk for falls r/t [related to] Disease process: Hemiplegia and hemiparesis . resident will be free of falls . Anticipate and meet The resident ' s needs . Be sure The resident ' s call light is within reach and encourage the resident to use it . The resident needs prompt response to all requests for assistance . appropriate footwear . Medication adjustment . Medication Review . Non-Skid tape . FWW [front wheel walker] . Behavioral Health Specialist . safe environment . floor free from spills . Resident 1 ' s care plans were reviewed, the MDSC stated Resident 1 was known to be non-compliant and interventions of encourage call light, call light in reach, educate on risks versus benefits were not effective interventions. The MDSC stated the care plan interventions did not address the root cause of Resident 1 ' s falls which was poor safety awareness, impulsiveness and noncompliance with call light and assistive devices. The MDSC stated Resident 1 ' s care plans were not individualized for Resident 1 ' s needs. During a concurrent interview and record review on 4/1/25 at 12:13 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 had a fall on 3/15/25 when the adjoining neighbor opened the bathroom door as he tried to enter, causing him to hit his head and fall but the resident was not sent to the ED. The ADON stated he had an X-ray of his hip done at the facility with negative results. The ADON stated Resident 1 had an unwitnessed fall on 3/16/25 and was found on the floor by one of the charge nurses in between his bed and his neighbor ' s bed. The ADON stated he complained of pain and the nurse was given the authorization from hospice to send him to the ED. The ADON stated a CT scan was performed in the ED and Resident 1 had a comminuted fracture to his left trochanter and he was sent back to the facility on the morning of 3/17/25. The ADON stated Resident 1 had another fall on 3/17/25 after he was sent back to the facility with orders to be non-weight bearing on his left leg. The ADON stated the resident had ambulated to the doorway behind his wheelchair, turned around and fell on the floor in front of the charge nurse. The ADON stated Resident 1 rarely used his call light to ask for assistance to the bathroom and back. The ADON stated Resident 1 ' s fall risk assessment indicated he was at high risk for falls. Resident 1 ' s care plans were reviewed, the ADON stated the care plan was not updated after the falls on 3/15/25 and 3/16/25 because it happened on the weekend. The ADON stated the IDT met on 3/17/25 and the care plans were updated. The ADON stated care plans were a plan of care individualized to each resident to take care of their own specific needs. The ADON reviewed Resident 1 ' s fall care plan interventions and stated they were not specific and individualized to him and could apply to any resident. The ADON stated Resident 1 continued to fall despite the facility ' s routine two-hour checks for all residents. The ADON stated Resident 1 needed more frequent supervision to prevent his falls. The ADON stated Resident 1 ' s care plan did not address the amount of supervision Resident 1 required for safety. Resident 1 ' s MDS Section GG, was reviewed. The ADON stated the MDS indicated Resident 1 required supervision or touch assistance for toileting and ambulating short distances which meant somebody needed to be with him to go to the bathroom. The ADON stated Resident 1 should a gait belt (a strap worn around a person ' s waist, used by caregivers to assist with walking) on and a walker with him for safety. The ADON stated Resident 1 ' s fall care plans did not address caregivers helping him to the bathroom or use of a gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview and record review on 4/1/25 at 1:21 p.m. with the Director of Nursing (DON), the DON stated she was concerned because Resident 1 had three falls within three days. The DON stated she had discussed Resident 1 ' s falls with his hospice agency because they were also responsible to help prevent falls. Resident 1 ' s IDT notes were reviewed. The DON stated the root cause of Resident 1 ' s falls were his impulsive behaviors, poor safety awareness and non-compliance. The DON reviewed Resident 1 ' s fall care plan and stated the interventions to remind him to use the call light and education were not effective in preventing his falls because of his non-compliance. The DON stated Resident 1 ' s care plan interventions did not address the level of supervision and assistance needed for ADLs (activities of daily living-fundamental self-care tasks to maintain independence and well-being such as bathing, dressing, toileting and mobility) and to prevent falls. The DON stated, we could not do anything to prevent his falling. During a telephone interview on 4/2/25 at 7:51 AM with LVN 2, LVN 2 stated she had witnessed Resident 1 ' s fall on 3/17/25. LVN 2 stated she was standing across the hallway from his room at the medication cart and when she turned around, the resident was standing in his doorway without staff assistance. LVN 2 stated she talked to him, and he turned around quickly put his hands in front of him and fell on to the ground. LVN 2 stated she assessed the resident and put him into his wheelchair. LVN 2 stated she had discussed Resident 1 ' s non-weight bearing status with him earlier in the day and he told her he wanted to show himself that he could still get up and walk. LVN 2 stated before Resident 1 broke his hip, he would get up to the bathroom by himself and would not use a walker, steadying himself by grabbing on to furniture or the wall. LVN 2 stated Resident 1 was at high risk for falls because he was stubborn, non-compliant, impulsive and had poor safety awareness. During a review of the facility ' s policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, . Based on previous evaluations and current data, the 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 . pain . functional impairments . balance and gait disorders . The staff . will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions . staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stop . staff will identify and implement relevant interventions . to try to minimize serious consequences of falling . staff will monitor and document each resident ' s response to interventions intended to reduce falling . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to reconsider possible causes . Based on observation, interview and record review, the facility failed to ensure residents received adequate supervision to prevent falls for one of three sampled residents (Resident 1) when Resident 1 was assessed to be at risk for falls on 1/22/25, had impulsive behavior and staff were aware of Resident 1 not using the call light to request assistance to walk in his room and effective individualized interventions to prevent falls were not implemented. Resident 1 experienced an unwitnessed fall on 3/15/25, fall on 3/16/25 and a fall on 3/17/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	These failures resulted in Resident 1's avoidable fall on 3/16/25 sustaining a fracture of the left greater trochanter (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis) causing pain and decreased mobility which required transportation to the emergency department (ED) for assessment and treatment of his injury and was readmitted to the facility. Resident 1 had a third fall on 3/17/25 which placed the resident at risk for further serious injury. Findings: During a concurrent observation and interview on 4/1/25 at 9:30 a.m., with Resident 1, Resident 1 was lying in bed, dressed and groomed. There was a wheelchair and four-wheeled walker observed near his bed. Resident 1 complained of pain to bilateral hips and stated he had fallen, and his left hip was swollen and painful. Resident 1 stated he fell about a week ago (on 3/15/25) when he rushed to the bathroom without his walker or wheelchair and at the same time, the resident from the adjoining room pushed the bathroom door open hitting him in the head causing him to fall on the ground. Resident 1 stated he was hit on his forehead, back of his head on the left side and landed on his left hip. Resident 1 stated, It hurt really bad. Resident 1 stated he had a portable X-ray done at the facility which did not show any fractures but was sent to the emergency room the next day where he was told he had a hip fracture. Resident 1 stated the fracture was not severe enough to require surgery, so he was sent from the ED back to the facility. Resident 1 stated he was independent to go to the bathroom and back, so he did not use his call light or walker. During a review of Resident 1's CT scan (CT-specialized Xray machine to create detailed images of the body) results from the acute care hospital (ACH), dated 3/17/25, the CT scan results indicated, . Acute comminuted fracture [type of fracture where the bone breaks into three or more pieces] of the greater trochanter of the left femur with minimum displacement [broken ends of bone are relatively aligned] . 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 left sided hemiplegia (weakness or paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is disrupted), palliative care (specialized medical care focused on relieving symptoms of a serious illness), squamous cell carcinoma of skin (type of skin cancer), Type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), transient cerebral ischemic attack (temporary interruption of blood flow to the brain) and spinal stenosis (condition where the spinal canal becomes narrowed). 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 11 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 11's cognition was moderately impaired. During an interview on 4/1/25 at 9:41 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 would not use his call light to call for help. CNA 1 stated Resident 1 would take himself to the bathroom without assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/1/25 at 10:12 a.m. with CNA 2, CNA 2 stated Resident 1 would get out of bed and walk to the bathroom independently. CNA 2 stated Resident 1 used the call light when he needed pain medication but otherwise did not call for help. CNA 2 stated Resident 2 would hold onto items to walk to the bathroom such as the bedside table, footboard and walls to get to the bathroom. CNA 2 stated Resident 1 needed to have supervision and use his walker to ambulate safely. During a review of Resident 1's fall care plan, dated 3/16/25, the care plan indicated, . unwitnessed fall on 3/15/25 and 3/16/25 . be free of complications r/t [related to] unwitnessed fall . Assess pain . Educate [Resident 1] to utilize call light and to wait for assistance . Medication adjustment/review . Notify MD [Medical Doctor] for any significant changes . X-ray to hip bilateral with pelvis . During a review of Resident 1's fall care plan dated 3/17/25, the care plan indicated, . witnessed fall 3/17/25, no injury . will not have any delayed trauma . Monitor for any s/s [signs/symptoms] delayed trauma . Q [every] shift monitoring . Refer to [Name of Behavioral Health] . During a concurrent interview and record review on 4/1/25 at 10:29 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was usually assigned to Resident 1. LVN 1 stated Resident 1 tended to get up to the bathroom and back to bed without supervision. Resident 1's progress notes were reviewed, LVN 1 stated Resident 1 fell on [DATE], 3/16/25 and 3/17/25. 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]-Change in Condition, dated 3/15/25, was reviewed. The SBAR indicated, . at 1840 (6:40 p.m.) I heard a commotion from resident's room. I entered to find resident lying on his back in the space between him and his roommates bed . Assessment . abras [abrasion-superficial scrape of the skin] on to L [left] hip and ST [skin tear] to L shin . resident stated he was trying to pull open the bathroom door and the resident from adjoining room, who was in the bathroom at that time, pushed the door from the inside striking the resident in the head which caused him to fall and land on back . LVN 1 stated two rooms shared the same bathroom. Resident 1's SBAR-Change in Condition, dated 3/16/25, the SBAR indicated, . nurse heard resident calling for help in the room. Found resident lying in supine [lying face upward] position in between the bed spaces. He said he was getting pants in closet and fell backwards and blacked out for a bit before he became conscious again . Resident had a fall the day before . left hip pain with skin tear to left shin . contusion [bruise] and raised bump on left back of head . left hip in excessive pain . Called hospice [specialized care focused on end of life treatment] at 2120 [9:20 p.m.] to update on resident's situation and to tell them resident wants to go to the hospital . Transported on gurney [wheeled stretcher] . Resident 1's SBAR-Change in Condition, dated 3/17/25, the SBAR indicated, . Resident in hallway standing writer immediately saw resident and told him why are you standing up? Resident turned around and fell on floor with arms out stretched . Resident continues to use bathroom unattended despite constant verbal reminders by staff that he's [sic] non wt [weight] bearing . no new injuries . I just want to prove to myself I can still do it [walk] . LVN 1 stated Resident 1 would walk from his bed to the bathroom and back by himself. LVN 1 stated Resident 1 would not use the call light and interventions to remind him or educate him to use it were not effective. Resident 1's fall risk care plans were reviewed. LVN 1 stated the interventions were basic and would apply to most residents. LVN 1 stated the care plans did not address Resident 1's specific needs, such as his noncompliance with the call light. LVN 1 stated Resident 1 needed more frequent supervision and to be put on a toileting schedule because he frequently ambulated to the bathroom by himself. (continued on next page)

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	055410	A. Building B. Wing	04/01/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1's 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, dated 3/17/25, the IDT note indicated, . IDT meeting due to s/p [status post] 2 unwitnessed falls 03/15 and 03/16 [2025] . Fall #1 03/15/25 . Observation/Evaluation (LVN) . heard a commotion from resident's room . find resident lying on his back in the space between him and his roommate's bed . Resident was noted to have a slightly discolored area to the right side of his forehead as well as an abrasion to L hip and ST to L shin . Fall #2 03/16/25 . heard resident calling for help in the room . Found resident lying in supine position in between the bed spaces . Bump on forehead and left hip pain with skin tear to left shin . Left hip in excessive pain . Resident's appeared more confused than baseline, story changed multiple times . Root Cause . 1st fall, Resident attempted to ambulate independently to the bathroom, he grabbed knob to bathroom door and when he did, another resident was in the bathroom and pushed the door outward toward resident, causing the door to make contact . which caused him to fall to floor . 2nd fall, Resident attempted to ambulate in his room, went to the closet to get his pants and pulled on pants from hanger and stated, I was blacking out and I fell to the floor . Resident does not use call light or ask for assistance . even after education provided to use call light. Resident has a walker at bedside and refuses to use it with transfers or ambulation [act of walking] . Resident had an X-ray in facility on 03/16 after 1st fall . which resulted NEGATIVE . Resident was sent out to [name of acute Emergency Department] per resident's request and authorization from [Name] Hospice and a CT scan was ordered and resulted: Acute Comminuted fracture of the greater trochanter of the left femur with minimum displacement . During a review of Resident 1's IDT Review, dated 3/18/25, the IDT note indicated, . Resident brought to IDT meeting due to s/p witnessed fall 03/17/25 . Frequent falls . Resident continues to use bathroom unattended despite constant verbal reminders by staff that he's non wt [weight] bearing . Resident interviewed: I just want to prove to myself that I can still do it . ROOT CAUSE: Resident is impulsive, resistant to redirection and does not follow any orders provided. After education provided to resident to not bear weight [act of supporting the weight of something] on left lower extremity [leg], resident got up from his bed and ambulated through his room to the door, causing him to fall to floor . Continue current POC [plan of care]. Refer to [name] Behavioral Health Specialist provided by [name] Hospice. Care Plan reviewed and updated . During a review of Resident 1's Risk For Falls, dated 1/22/25, the fall risk indicated Resident 1's score was 10 which placed him in the High fall risk category. During a concurrent interview and record review on 4/1/25 at 11:25 a.m. with the MDS Coordinator (MDSC), Resident 1's MDS Assessment, Section GG-Functional Abilities, dated 2/11/25, was reviewed. The MDS Section GG indicated, .C. lying to sitting on side of bed . code 04 [Supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance)] . D. sit to stand . code 04 . F. Toilet transfer . code 04 . Walk 10 feet . code 04 . The MDSC stated Resident 1 should have a CNA standing there watching him, ready to assist as needed when ambulating, including to the bathroom and back to bed. The MDSC stated Resident 1 was known to be a high fall risk, non-compliant and did not use his call light to call for assistance. Resident 1's fall risk care plan dated 3/14/24, the care plan indicated, . resident is at risk for falls r/t [related to] Disease process: Hemiplegia and hemiparesis . resident will be free of falls . Anticipate and meet The resident's needs . Be sure The resident's call light is within reach and encourage the resident to use it . The resident needs prompt response to all requests for assistance . appropriate footwear . Medication adjust [TRUNCATED]