STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055523	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Post Acute Center	250 N. Verdugo Road Glendale, CA 91206

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44429 Based on interview and record review, the facility failed to follow physician orders for Laboratory Services and implemented fall care plan interventions for one of three sampled residents (Resident 1), who has a diagnosis of dementia (mental decline of memory, thinking and reasoning) and assessed at high risk for falls, by failing to: 1. Ensure to have a Fall Protocol (a system of rules that explain the correct conduct and procedures to be followed in formal situations) and Fall Prevention Program in place, as indicated in the facility ' s Fall Care Plan Interventions developed for Resident 1 on 2/4/2025 and 2/15/2025, and physician orders on 2/17/2025 and 2/18/2025. In an interview, the Assistant Director of Nurses (ADON) stated the facility did not have a fall protocol or fall prevention program in place. 2. Follow up with the facility ' s Laboratory Services, when the facility ' s Laboratory (Lab) Technician (LT) could not obtain Resident 1 ' s blood sample on 2/5/2025, as indicated with physician orders for complete blood count (CBC - blood test for overall health and infection) and comprehensive metabolic panel (CMP - blood test that checks the bodies fluid levels, liver and kidney function), due to too much bruising. 3. Follow physician orders to collect urine on 2/12/2025, due to a probable contamination of Resident 1 ' s previously collected urine sample for culture and sensitivity (C/S - checks for bacteria in a urine sample to determine which antibiotics [medications that are used to treat bacterial infections] are effective against bacteria found in urine). The above deficient practices resulted in Resident 1 having four unwitnessed falls, two episodes of falls that occurred on 2/6/2025, one fall occurred on 2/16/2025, and another fall occurred on 2/19/2025. Resident 1 experienced acute pain due to multiple traumas from falls. Resident 1 did not receive antibiotic medications timely to treat urinary tract infection and did not receive timely medical/nursing interventions for abnormal blood values detected through laboratory blood tests. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/2025, the facility transferred Resident 1 to the General Acute Care Hospital (GACH 2) for lethargy (deep unresponsiveness and inactivity). In GACH 2, Resident 1 was diagnosed with hypernatremia (a condition of high sodium levels in the blood, is most commonly caused by dehydration due to reduced fluid intake or increased fluid loss), dehydration (harmful reduction in the amount of water in the body), urinary tract infection with severe sepsis (life threatening infection), UTI (infection in the urine), thrombocytopenia (abnormally low blood platelets [helps blood to clot] count). While in GACH 2, Resident 1 received intravenous (IV) fluids for hydration, antibiotic medications that included vancomycin (antibiotic medication that treats several bacterial infections) for UTI and sepsis. On 3/4/2025, Resident 1 was discharged to another facility as requested by family members. Findings: During a review of GACH 1 emergency room (ER) Records dated 1/28/2025, the GACH 1 ER Records indicated that prior to admission to the facility, Resident 1 was brought to the GACH 1 ER Record on 1/28/2025, due to a fall at home resulting in a left leg femur (largest bone in the body) fracture (broken bone). The GACH 1 ER Record indicated Resident 1 had an open reduction internal fixation ([ORIF] - a surgery to repair a severely broken bone) surgery on 1/29/2025. The GACH 1 ER Record further indicated Resident 1 had a history of a right hip fracture with ORIF repair on 12/2024. During further review of Resident 1 ' s GACH 1 laboratory blood tests dated 1/28/2025, the GACH 1 record indicated that prior to admission to the facility, Resident 1 ' s urinalysis (test to detect infection in the urine) test result indicated the following information: 1. Urine character was yellow in color. 2. [NAME] Blood Cells (WBC - protect the body from infections) count was between 0 -5/Hpf (unit of measurement - normal WBC range should be less than 5/Hpf). 3. Blood was 2+ abnormal (reference range should be negative). 4. Protein level 1+ abnormal (reference range should be negative). 5. Bacteria was negative (reference range should be negative). 6. Leukoesterase (an enzyme produced by WBC, and its presence in urine, can indicate infection [reference range should be negative]) was negative. During a review of Resident 1 ' s Admission Record [AR], the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included history of falling, dementia with agitation (restlessness), psychosis (a mental health condition characterized by a loss of touch with reality), fracture of left femur, anemia (a condition in which there is a lower-than-normal number of red blood cells), and diabetes mellitus (a chronic disease characterized by high blood sugar levels). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Care Plan titled Resident 1 was at High Risk for Unavoidable Falls with Injury dated 2/4/2025, the care plan indicated the resident ' s risk factors for being at high risk for falls were related to limited mobility, gait/balance problems, incontinence (unable to control the flow of urine and the escape of stool), psychoactive drug use, unaware of safety needs, and vision hearing problems. The care plan interventions included anticipating and meeting the resident ' s needs, reminders to staff that resident needed prompt response to all request for assistance, and to follow facility fall protocol. The care plan further indicated that the facility would review Resident 1 ' s past falls and attempt to determine the possible root causes of the falls to alter and remove any potential causes. During a review of Resident 1 ' s Telephone Orders (TO) dated 2/4/2025 timed at 8:25 PM, the TO indicated orders for CBC and CMP, Urinalysis (test to detect infection in the urine) and urine culture (lab test that checks for bacteria and other germs in the urine). During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the Patient ' s health status) signed by the resident ' s attending physician on 2/5/2025, the HPE indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Laboratory (Lab) Services Order Requisition dated 2/5/2025 timed at 12 PM, indicated Blood specimen not collected. The Lab Order indicated a handwritten comment that showed UTO [unable to obtain), lots of bruises. The Lab Order further indicated the tests ordered for Resident 1 indicated the following information: 1. CBC with diff ([differential] refers to a test that measures the percentage of white blood cell (WBC) present to identify potential infection)- STAT - Please call the Lab 2. CMP with diff - STAT - Please call the Lab. During a review of Resident 1 ' s Lab Results Report dated 2/5/2025, the lab report indicated the following information regarding Resident 1 ' s urinalysis: 1. Urine character was cloudy. 2. WBC count elevated at 428/Hpf (unit of measurement - normal WBC range should be less than 5/Hpf). 3. Blood with Large amount (reference range should be negative). 4. Protein level at 50 (reference range should be negative). 5. Bacteria was Few (reference range should be negative). 6. Leukoesterase was Large (reference range should be negative) in amount. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Lab Results Report with collection date 2/5/2025 and reported date of 2/10/2025, the lab report indicated Culture, Urine. The Lab Report indicated Multiple organisms isolated probable contaminant, repeat culture if indicated. During a review of Resident 1 ' s Nursing Progress Note dated 2/6/2025 timed at 10:44 AM, the Note indicated that at 10:10 AM the CNA called the RN to inform that Resident 1 was found on the floor. The Progress Note further indicated Resident 1 was observed by the RN in a sitting position on the floor on the right side of her bed holding on to the bedrail. The Progress Note indicated Resident 1 verbalized she wanted to go to the bathroom by herself but slide. The Progress Note indicated Resident 1 denied pain at the time. During a review of Resident 1 ' s Nursing Progress Note dated 2/6/2025 timed at 1:07 PM, the Progress Note indicated the Primary Medical Doctor (PMD) was notified that Resident 1 was complaining of pain at the surgical site and PMD ordered a stat (urgent) x-ray of the left hip and femur. During a review of Resident 1 ' s Nursing Progress Note dated 2/6/2025 timed at 4:19 PM, indicated at 3:30 PM (5 hours after the first fall incident at 10:44 AM) Resident 1 had another unwitnessed fall and was found kneeling on the floor. During a review of Resident 1 ' s Nursing Progress Note dated 2/6/2025 at 6:19 PM, the Note indicated the urinalysis report was faxed to the PMD office and indicated No new orders as of yet. During a review of Resident 1 ' s Radiology Result Report with examination date of 2/6/2025 and report date of 2/7/2025, the Radiology Report indicated Resident 1 had a left hip Xray on 2/6/2025 secondary to acute (severe or sudden onset) pain due to trauma (physical injury). During a review of Resident 1 ' s Radiology Result Report with examination date of 2/6/2025 and indicated for acute pain due to trauma. The Radiology Report indicated Non-specific soft tissue swelling, and intramedullary nail and interlocking screws for mildly displaced left proximal femoral fracture. No evidence for hardware complication. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated 2/7/2025, the MDS indicated Resident 1 had a severely impaired cognition (thought process). The MDS indicated Resident 1 was dependent to staff during care needed for toileting, showering, dressing, sit to stand, chair to bed transfer and rolling left to right in bed. The MDS indicated that Resident 1 had a history of falling. The MDS indicated Resident 1 had a fall any time in the last month and had fracture related to a fall. During a review of Resident 1 ' s Nursing Progress Notes dated 2/10/2025 timed at 1:20 PM, the Note indicated urine C/S results in, multiple organisms isolated probable contaminant, repeat culture as indicated. The Note indicated the C/S result was sent to the PMD ' s office and informed PMD. The Note indicated NNO (No new orders) at this time. During a review of Resident 1 ' s physician orders indicated another order dated 2/12/2025 to collect urine via in and out catheter (a temporary urinary catheter that is inserted into the bladder to drain urine and then removed). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Care Plan titled Falls were Affecting Resident 1 Safety due to a History of Recurrent Falls, dated 2/15/2025, the care plan indicated the resident ' s fall risk issues were related to impaired mobility and cognitive impairment, increasing the risk for injury. The care plan indicated nursing would implement a fall prevention program which includes frequent safety checks and environmental modifications to minimize risks. The care plan further indicated staff would educate fall prevention strategies and encourage participation in structured activities to improve safety awareness. During a review of Resident 1 ' s Nursing Progress Note dated 2/16/2025 timed at 10:15 AM, indicated Resident 1 was found lying on the floor mat, had facial grimacing (facial expression when experiencing pain), moaning (sound made when in pain) and pain medication was offered. During a review of Resident 1 ' s Radiology Result Report with examination date of 2/17/2025 and report date of 2/17/2025, the Radiology Report indicated Resident 1 had a bilateral (two views) hip Xray on 2/17/2025 which indicated Resident 1 ' s old hip fracture on the right with hardware (surgical screws) and the left hip was transfixed (unable to move) with nails and screws. The report indicated that Resident 1 had a left shoulder Xray with two views and no obvious osteopenia (loss of bone density), no acute fracture and no dislocation. During a review of Resident 1 ' s PMD Progress Note dated 2/17/2025, the PMD Progress Note indicated Resident 1 was sitting at the nursing station disoriented (confused not knowing where you are), agitated (upset), anxious, keeps hitting her legs on the floor and knees on the drawers. The PMD Progress Note indicated Resident 1 needed fall precautions. During a review of Resident 1 ' s Nursing Progress Note dated 2/18/2025 time at 4:03 PM, the Nursing Progress Note indicated Resident 1 was seen by PMD with orders to enforce fall precautions with bilateral (involving two sides) floormats and bed in lowest position. During a review of Resident 1 ' s Nursing Progress Note dated 2/19/2025, the Nursing Progress Note indicated at around 12 PM Resident 1 ' s roommate called for help because Resident 1 was in her room lying on the floor on her left side. During a review of Resident 1 ' s COC dated 2/19/2025 timed at 12:02 PM, the COC indicated Resident 1 had another fall and was found sitting in front of her bed with back against the bed board. During a review of Resident 1 ' s Care Plan titled Unwitnessed Fall dated 2/19/2025, the care plan interventions indicated the facility would anticipate needs of Resident 1. During a review of Resident 1 ' s Telephone Orders (TO) dated 2/24/2025, the TO indicated to transfer Resident 1 to the GACH 2 via 911 (emergency services) due to lethargy. During a review of Resident 1 ' s Nursing Progress Note dated 2/24/2025 at 1:55 PM, the Note indicated at 12:30 PM, Resident 1 was found lethargic (feeling tired and sluggish), eyes fixed open (to look at someone or something steadily), awake but non-verbal and slow to arouse (awaken). The Note indicated at 12:40 PM, Resident 1 was transferred to the GACH 2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of GACH 2 records, the GACH 2 Emergency Department (ED) Reports dated 2/24/2025 timed at 4:54 PM indicated Resident 1 arrived at the GACH 2 ED with hypoxia (low oxygen level) and oxygen saturation (amount of oxygen in the blood with normal levels of 95 %to 100%) of 91% on room air (the normal air one breathes). The GACH 2 ED Reports indicated the facility staff reported that Resident 1 appeared lethargic than normal. During the same review of the GACH 2 ED Report dated 2/24/2025, the Report indicated abnormal laboratory values for Resident 1 ' s CMP obtained on 2/24/2025. The CMP indicated Resident 1 was significant for hypernatremia with elevated sodium levels of 155 mEq/L (unit of measurement - normal ranges between 135 - 145 mEq/L), elevated Blood Urea Nitrogen (BUN - measures waste in the blood stream - normal ranges between 6 - 20mg/dL) level of 60 mg/dL and elevated ammonia levels (measures waste in the blood stream - normal levels between 15 - 45 umol/L (unit of measurement) of 147 umol/L. The GACH 2 ED report further indicated that Resident 1 ' s abnormal CMP contributed to Resident 1 ' s altered mental status (a change in mental function). Furthermore, the GACH 2 ED Reports indicated Resident received IV antibiotics and IV fluids while in the GACH 2 ED. During a review of Resident 1 ' s GACH 2 Records indicated another urinalysis and C/S was obtained for Resident 1 at GACH 2 on 2/24/2025. The GACH 2 Records titled Urinalysis & Stools dated 2/24/2025 indicated Resident 1 ' s urine color was now light orange, urine appearance was extra turbid (cloudy), urine had blood 3 + mg/dL (unit of measurement which indicates blood in the urine) and leukoesterase level was further elevated to 500 hpf (unit of measurement - normal range is 0 to 5 hpf). During a review of Resident 1 ' s GACH 2 Records C/S results, titled Microbiology dated 2/25/2025, the C/S result indicated the urine culture had > 100,000 cfu/ml (unit of measurement) of enterococcus faecium (bacteria that is commonly found in UTI - normal range between 1.001 - 1.035 cfu/ml). The C/S result indicated the enterococcus faecium bacteria was susceptible (means that the specified antibiotic would effectively stop the specific bacterial growth, making the specified antibiotic a good choice for treatment) to Vancomycin. During a review of Resident 1 ' s GACH 2 Records titled Patient Information Sheet dated 3/5/2025, indicated Resident 1 ' s final diagnoses included hypernatremia, dehydration, severe sepsis (life threatening infection), UTI, altered mental status and acute kidney failure. During a review of Resident 1 ' s GACH 2 Records titled Discharge Summaries Notes dated 3/4/2025 indicated Resident 1 Discharge diagnoses was hypernatremia, UTI with severe sepsis, lactic acidosis (occurs when tissues are deprived oxygen) and urine was growing enterococcus, Enterococcus Faecium UTI treated with Vancomycin as per urine C & S, Thrombocytopenia (low blood platelets [helps blood form a clot] count). Resident 1 prognosis (the outcome from illness) was poor and was transferred to the transitional care unit (short stay area). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 3/11/2025 at 3:30 PM and record review of Resident 1 ' s Lab Results Report dated 2/5/2025 and physician orders, the Assistant Director of Nursing (ADON) stated on 2/5/2025, the lab results indicated that Resident 1 ' s urine character was cloudy and had high levels of white blood cells. The ADON stated the urinalysis results were faxed to PMD, and no new orders were given. The ADON stated the lab results indicated that Resident 1 probably had a urinary tract infection (UTI - infection in the urine). The ADON stated she could not find documented evidence that PMD was made aware of the Lab result that indicated to repeat urine culture dated 2/10/2025, and if a urine was collected from Resident 1 via in and out catheter for the physician order dated 2/12/2025. During a concurrent interview on 3/11/2025 at 3:50 PM and record review of Resident 1 ' s Laboratory Services Order Requisition dated 2/5/2025 timed at 12 PM, the ADON stated the lab report indicated the lab technician was unable to obtain the blood sample for the CBC and CMP ordered by PMD on 2/3/2025. The ADON stated that the lab report indicated for the facility to call the laboratory. The ADON stated that the licensed nurses did not follow up and call the laboratory to get another blood draw from Resident 1 for the physician orders of CBC and CMP. The ADON stated that the licensed nurses did not follow up and contact the PMD regarding the lab orders not being done The ADON stated the CBC and CMP should have been done as ordered by the physician because the blood tests would have indicated that Resident 1 had UTI and other changes in condition. During an interview on 3/11/2025 at 4:15 PM, Licensed Vocational Nurse (LVN) 1 stated that when Resident 1 was admitted on [DATE], the resident had been moving around in and out of bed and having frequent falls. LVN 1 stated Resident 1 ' s room was changed after the first two falls on 2/6/2025 to a room right in front of the Nursing Station so staff can provide more frequent observations. LVN 1 stated that on 2/24/2025 at around 12 PM Resident 1 had a change of condition and became lethargic and was not moving around or trying to get out of bed. LVN stated she noticed Resident 1 was just starring and not responding then she notified her supervisor, 911 was called and Resident 1 was transferred to the GACH 2. During a telephone interview on 3/12/2025 at 9:39 AM, Family Member (FM 1) stated that the facility staff called and informed her about Resident 1 ' s fall on 2/6/2025 at 10 AM. FM 1 stated that when she went to visit Resident 1 at the facility on 2/6/2025, she found Resident 1 lying on the floor at around 3 PM inside her room and FM 1 had to go get help. FM 1 stated that on 2/24/2025 the charge nurse called her about Resident 1 being lethargic and was not responding and was transferred to the GACH (2). FM 1 stated that PMD contacted her after Resident 1 was admitted to the GACH and stated that it was a common thing for Resident 1 to have a UTI. During a concurrent interview on 3/12/2025 at 11:45 AM and record review of Resident 1 ' s care plan titled Resident 1 was at high risk for unavoidable falls with injury dated 2/4/2025, the ADON stated the licensed nurses did not implement a fall protocol and follow the care plan interventions to review Resident 1 ' s past falls to determine the cause of Resident 1 ' s falls. The ADON stated that during a record review of Resident 1 ' s Nursing progress notes for February 2025, the notes indicated that Resident 1 had two unwitnessed falls on 2/6/2025 in her room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview on 3/12/2025 at 11:45 AM, the ADON stated that Resident 1 ' s care plans was not updated to reflect that Resident 1 had two unwitnessed falls and that there were no additional and revised interventions put in place to prevent furthers falls. The ADON stated by not updating Resident 1 ' s care plan after having two falls on 2/6/2025, the facility placed Resident 1 at further risks for falls and injuries related from recurrent falls. The ADON stated she could not find documented evidence that an Interdisciplinary Team Meeting (IDT) was conducted to address the two falls that happened to Resident 1 on the same day of 2/6/2025. The ADON further stated that Resident 1 had another unwitnessed fall in the resident ' s room on 2/16/2025, when Resident 1 was found lying down on her back with facial grimacing. The ADON stated Resident 1 had another fall on 2/19/2025 at 12 PM, and Resident 1 ' s roommate called for help while Resident 1 was on the floor inside their room. The ADON stated the resident was found on the left in a side lying position at the backside of the bed. The ADON stated she could not find documented evidence from 2/19/2025 up to present to indicate Resident 1 was being frequently monitored by facility staff. During the same interview on 3/12/2025 at 11:45 AM, the ADON reviewed Resident 1 ' s fall care plans developed on 2/4/25 and 2/15/25, the ADON stated the fall care plans included under care plan interventions that the facility would implement fall protocol or fall prevention program for Resident 1. The ADON stated the facility did not have fall prevention program. The ADON stated the nurses should have been monitoring Resident 1 for frequent safety checks according to the indicated care plan interventions. The ADON stated if the facility revised the resident ' s fall care plan to indicate that Resident 1 had multiple falls and had conducted an IDT care plan meeting to address the underlying medical issues of Resident 1 ' s multiple falls, then it would have prevented or minimized the number of falls of Resident 1 the facility During a phone interview on 3/13/2025 at 9:53 AM, the PMD stated she was not notified by the facility staff about Resident 1 ' s CBC and CMP blood tests not being done by the facility laboratory services. The PMD stated, the blood tests should have been done and followed up on by the facility. The PMD stated the facility had faxed the urinalysis lab results on 2/6/2025 to her office but Resident 1 had received antibiotic at GACH 1 prior to admission to the facility which should have covered Resident 1 for the UTI. The PMD stated that Resident 1 and other residents in the facility of the same age would all have abnormal urine lab results. However, the PMD stated the facility did not notify her that Resident 1 ' s urine C/S indicated possible contaminant and repeat culture, if indicated. The PMD stated the urine should had been collected again and urine C/S should had been repeated. During the same phone interview on 3/13/2025 at 9:53 AM, the PMD stated that Resident 1 had a history of frequent falls at home that is why Resident 1 was transferred to the facility but Resident 1 was having frequent falls at the facility. The PMD stated when she went to visit Resident 1 at the facility on 2/17/2025, her expectations and discussion with the facility nursing staff was to ensure that Resident 1 had increased monitoring and supervision because of Resident 1 ' s diagnosis of dementia and repeated falls. The PMD stated when Resident 1 was in her wheelchair, (Resident 1) was always looking down on the floor as if she were looking to fall. The PMD stated that FM 1 found Resident 1 on the floor inside her room. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 3/24/2025 at 11:38 AM and record review of Resident 1 ' s Nursing Progress Notes dated 2/10/2025 timed at 1:20 PM, the Director of Nursing (DON) stated that Resident 1 ' s urine C/S indicated to repeat the urine culture as indicated. The DON stated the urine sample was not collected from Resident 1, as ordered by the PMD on 2/12/2025. During the same concurrent record review of Resident 1 ' s TO dated 2/12/2025 timed at 11:47 AM, the DON stated that PMD ' s order indicated in and out catheter (method for collecting a urine sample) for urine collection was discontinued in the system and completed, however, the urine sample was not collected. The DON stated that the urine culture would have indicated Resident 1 ' s UTI treatments and other changes in condition. During a review of the facility ' s P&P titled Lab and Diagnostic Test Results - Clinical Protocol revised March 2018, indicated the staff will process test requisitions and arrange for tests and the laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. The P&P indicated when test results are reported to the facility, a nurse will first review the results, if staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. The P&P indicated the nurse will identify the urgency of communicating with the Attending Physician based on physician request. the seriousness of any abnormality, and the individual's current condition. During a review of the facility ' s P&P titled Fall Risk Assessment revised March 2018, indicated the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. The P&P indicated upon admission, the nursing staff and the physician will review a resident's record for a history of falls especially falls in the last 90 days and recurrent or periodic bouts of falling over time. The P&P indicated the staff, with the support of the attending physician, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, activities of daily living (ADL) capabilities, activity tolerance, continence, and cognition. During a review of the facility ' s P&P titled Falls and Fall Risk, managing revised 2/7/2024, indicated based on previous evaluations and current data, the nursing staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P indicated resident conditions that may contribute to the risk of falls include infection, delirium and other cognitive impairments, pain and incontinence. The P&P indicated the IDT team with the input of the attending physician, 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.