STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055626	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthcare Centre of Fresno	1665 M Street Fresno, CA 93721

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation interview and record review the facility failed to ensure an environment free of accident hazards for one of three sampled residents (Resident 1), when on 7/12/24 Resident 1 removed the window screw, opened the window, and jumped from the facility's second story. Certified Nursing Assistant (CNA) 1 noted a change in Resident 1's demeanor and heard Resident 1 stating she is done and did not report to licensed staff. This failure resulted in Resident 1 sustaining a fracture (broken bone) of multiple ribs on the right side, laceration (bleeding or tearing) of the liver, fracture of the right femur (bone of the thigh articulating at the hip and the knee), and right pneumothorax (when air builds up in the space between the chest wall and lung and puts pressure on the lung causing it to collapse). Findings: During an interview on 7/12/24 at 8:45 a.m., with the administrator (ADM). The ADM stated Resident 1 had opened the window in her room located on the second floor and jumped off to the ground on the first floor. The ADM stated Resident 1 was found by facility staff outside by the sidewalk. The ADM stated it appeared Resident 1 removed the protective screw from the window and pushed the window screen out to exit the window. The ADM stated he thought Resident 1 could have used a kitchen butter knife or utensil to unscrew the window screw as the window screws should have been tightly screwed in place. The ADM stated Resident 1 was transferred to the acute hospital for further evaluation. During a review of Resident 1's Admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis, systemic lupus erythematosus (long lasting disease that affects many parts of the body), hereditary and idiopathic neuropathy (nerve problem that causes pain, numbness, tingling, swelling or muscle weakness), spinal stenosis (causes pressure on the spinal cord or nerves), Major Depressive Disorder (mental health disorder causes persistent low or depressed mood), Borderline Personality Disorder (mental illness that causes loss of emotional control), anorexia (eating disorder that causes low body weight and intense fear of gaining weight), muscle weakness, post-traumatic stress disorder(disorder that develops when a person has experienced a scary, shocking, terrifying, or dangerous event), adult failure to thrive, homelessness, and patient noncompliance with other medical treatment and regimen due to unspecified reason. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/6/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 14 out of 15 (0 -7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 -12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During an observation on 7/12/24 at 9:16 a.m., in Resident 1's room, the window was observed to have a broken window screen and a removed screw was located near the window seal. The window was observed through the glass and the window screen was noted to be out of place, bent and pushed outward. A dining table was observed against the wall under the window border. There was a window screw positioned by the window seal next to the screw hole on the window base. When the window was pulled open to the left, it was noted to open all the way through. The screen was observed outward, bent and broken. Outside the window the rooftop to the first-floor dining room was located extended out about 10 feet outward allowing a walking distance. No footprints or drag marks noted were observed on the first-floor rooftop. During a concurrent observation and interview on 7/12/24 at 9:22 a.m., with Resident 2 in Resident 2's room, Resident 2 was observed lying in bed dressed, cleaned and groomed. Resident 2 stated she was moved to Resident 1's room the day prior and was recently residing in another room of the facility. Resident 2 stated she was asleep when Resident 1 left the facility and had not heard anything from Resident 1. Resident 2 stated that the prior day CNA 1 was heard communicating with Resident 1 when she heard Resident 1 say I'm done, it's over, this is the end. Resident 2 stated CNA 1 continued speaking with Resident 1 and then CNA 1 left for the night. Resident 2 stated the last thing she remembered was Resident 1 asking to close her privacy curtain and then going into the restroom using her wheelchair. Resident 2 sated Resident 1 remained in the restroom for a long period of time and could not recall when she exited the restroom. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis major depressive disorder, anxiety disorder (mental health disorder characterized by feeling of worry), insomnia and repeated falls. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 7 out of 15, which indicated Resident 2 was had severe cognitive impairment. (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	During an interview on 7/12/24 at 12:23 p.m., with CNA 1, CNA 1 stated he worked with Resident 1 often and was familiar with her care. CNA 1 stated he was assigned to care for Resident 1 the day prior and recalled talking with Resident 1 regarding her financial issues and how she needed to pay her cellphone bill and remove her car from the acute hospital parking lot. CNA 1 stated before dinner Resident 2 was moved into Resident 1's room. CNA 1 stated that following the roommate's arrival, Resident 1's demeanor changed appearing different and acting different. CNA 1 stated she began saying she is done. CNA 1 stated he asked Resident 1 what she meant and Resident 1 stated I am done with everything. CNA 1 stated he spoke with Resident 1 religiously and stated, only god decides when we leave this earth. CNA 1 stated he left Resident 1 after calming her and returned to Resident 1's room prior to the end of the shift. CNA 1 stated prior to the end of shift he asked Resident 1 if she needed anything, in which Resident 1 responded I don't need anything I am done with everything and CNA 1 proceeded to leave. CNA 1 stated during the last encounter with Resident 1 she was observed looking at her phone and writing on paper. CNA 1 stated he had not reported the change in Resident 1's behavior to the charge nurse and did not report it to the oncoming staff because he believed she was getting ready to leave the facility to retrieve her car as mentioned in a prior conversation. CNA 1 stated the screws on the windows were checked by the maintenance department and should have been screwed in place tightly and not removed easily. During an interview on 7/12/24 at 2:21 p.m., with RN 1, RN 1 stated she was in charge of Resident 1 on 7/11/24. RN 1 stated Resident 1's demeanor was not changed, and she had not noticed a difference with her care. RN 1 stated she was made aware that Resident 1 jumped from the second story through her room window. RN 1 stated the facility process was for CNA 1 to have notified the charge nurse to ensure Resident 1 was properly assessed and monitored for suicidal ideations. RN 1 stated all windows should have had a screw to lock them in place and keep them from opening more than 3-4 inches. RN 1 stated it was the maintenance department's responsibility to check all windows and screws were in place and secured. During an interview on 7/12/24 at 2:30 p.m., with the Nurse supervisor (NS), the NS stated the expectation was for CNAs to report any change in residents to the charge nurse immediately. NS stated it was important for CNA 1 to have notified the charge nurse for proper assessment, monitoring and proper care for Resident 1. During an interview on 7/12/24 at 2:43 p.m., with RN 2, RN 2 stated the facility expectation was for all CNAs to report any change in residents which included resident behavior. RN 2 stated the charge nurse should have been notified right away to assess the resident and ensure safety. RN 2 stated the facility windows should have a screw in place to securely keep the windows from opening all the way. RN 2 stated the maintenance department checked the windows to ensure they were secured. During an interview on 7/12/24 at 2:51 pm with CNA 2, CNA 2 stated it was the facility expectation for CNAs to report all changes including behavioral changes to the charge nurse immediately. CNA 2 stated if the resident was experiencing suicidal ideations, it was not appropriate for the CNA who was present to leave the resident. CNA 2 stated the facility maintenance department was in charge of ensuring windows were properly secured in all resident rooms. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 7/12/24 at 3:01 p.m., with the Maintenance supervisor (MS), the facility's Maintenance Daily log dated 7/8/24-7/12/24 was reviewed. The log indicated the MS was checking doors, locks & alarms, and conducting test operations for doors and locks but there was no documentation of the MS checking the windows or window screws. The MS stated the log did not indicate windows locks or security, but it was implied that they were checked daily during rounds when the facility doors were checked. The MS stated the window screws were approved by the fire marshal as appropriate for the facility. The MS stated the window screws were checked every morning during daily maintenance rounds but could not provide documentation. The MS stated all the window screws were secured in the facility and Resident 1 was able to open the window because she was actively having suicidal ideations. The MS stated that if a resident was experiencing suicidal ideations, they would find a way. During a telephone interview on 7/12/24 at 3:24 p.m., with Licensed Vocational Nurse (LVN) 1, the LVN stated she was in the facility assigned to work on Resident 1's floor. LVN 1 stated that on 7/12/24 at around 1:16 am she received a call from the nurse's station on the first floor alerting her that there was a person lying on the sidewalk outside. LVN 1 stated she proceeded to notify all staff including CNAs and nurses present to check all resident rooms on the floor to account for all residents. LVN 2 stated she went to the first floor and walked outside to find an ambulance and noted Resident 1 was lying on the sidewalk. LVN 1 stated Resident 1 was awake and talking stating that her chest was in pain. LVN 1 stated the emergency medical technicians (EMT) assessed Resident 1 and immediately transferred her onto the ambulance to the acute care hospital. LVN 1 stated she had not observed any belongings or items around Resident 1 or in the area where Resident 1 was lying. LVN 1 stated when Resident 1 was transferred she proceeded to go back to the second floor where Resident 1's room was located. LVN 1 stated she entered Resident 1's room and observed three piles of letters which indicated Resident 1 was experiencing suicidal ideations and attempted jump out of the second story. LVN 2 stated Resident 1's room window was closed but observed the window screen was broken and Resident 1's wheelchair was positioned by the room window. LVN 1 stated she spoke with the CNA 3 who was in charge of Resident 1. LVN 1 stated CNA 2 last observed Resident 1 on 7/12/24 at 12:40 am, according to CNA 3 Resident 1 was in the restroom. LVN 1 stated it was the facility expectation for any CNA or staff member present when any resident is expressing behavioral/emotional changes to notify the charge nurse immediately to ensure safety and proper assessment. During a telephone interview on 7/12/24 at 3:38 p.m. with CNA 3, CNA 3 stated she was assigned to Resident 1 on 7/12/24. CNA 3 stated Resident 1 had requested to use the wheelchair to go to the restroom during the night. CNA 3 stated that at approximately 11:45 pm, she observed Resident 1 still in the restroom when assisting Resident 2. CNA 3 stated she did not return to Resident 1's room until she was alerted by facility staff that a resident was found outside by the sidewalk and was identified as Resident 1. CNA 3 stated that when she entered Resident 1's room, she noted Resident 1's privacy curtains were closed, wheelchair was positioned by the window and when Resident 1's bed was observed there were letters indicating Resident 1 was experiencing suicidal ideations. CNA 3 stated she had received change of shift report from CNA 1 at the start of the shift. CNA 3 stated that CNA 1 reported that Resident 1 was upset because she did not want a roommate in the room but made no indication that Resident 1 was experiencing suicidal ideations. CNA 3 stated that if Resident 1 was expressing feelings of suicidal ideations, the charge nurse should have been alerted immediately. CNA 3 stated the facility process was for the CNA to alert the charge nurse, complete a stop and watch form (form that alerts facility staff that there was a change in resident during the shift) and remain with resident until safe. CNA 3 stated it was not an acceptable practice for CNA 1 to walk away from Resident 1 if Resident 1 was expressing her feelings because there was a potential for harm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's document titled, Stop and Watch Early Warning Tool, dated 2014, the document indicated, . if you have identified a change while caring for or observing a resident/patient, please circle the change and notify the nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can. Seems different than usual, talks or communicates less, overall needs more help . agitated or nervous more than usual, tired weak, confused or drowsy . During an observation on 7/15/24 at 3:24 p.m., Resident 1 was observed in the general acute care hospital (GACH). Resident 1 was observed lying in bed, asleep and difficult to arouse opening eyes when spoken to and then would close eyes to sleep. Resident 1 was observed to have bruising to the right arm, right hand, left hand and swelling. Resident 1's right hip and right lower extremity were wrapped with bandage. During an interview on 7/15/24 at 3:35 p.m., with the GACH RN 4, RN 4 stated Resident 1 had been experiencing drowsiness and drops in oxygen saturations. RN 4 stated that during Resident 1's stay, Resident 1 had been banging on the bed frame and throwing objects. RN 4 stated that Resident 1 had made comments stating she wished her head would have hit the floor but denied she was experiencing suicidal ideations (define). RN 4 stated Resident 1 had sustained a right femur fracture, open reduction and internal fixation (ORIF- surgery used to stabilize and heal a broken bone) of the right hip and stated Resident 1's whole right side of body was injured. RN 1 stated Resident had a diagnosis of depression with history of suicide attempts. During an interview on 7/15/24 at 3:47 p.m., with Resident 1, Resident 1 stated she was admitted into the emergency room after she had jumped out of her window on the second floor of the facility where she resided. Resident 1 stated she had attempted to land on her head to kill herself. Resident 1 stated the suicidal ideations were a result of staff treatment in the facility where she resided but could not state the treatment she was referring to. Resident 1 stated she had thoughts of suicide previously during a stay in the GACH. Resident 1 stated that on 7/12/24 she had requested the wheelchair from the charge nurse to use the restroom, then the charge nurse proceeded to exit her room. Resident 1 stated she had observed one screw on the room window that was easily removable, removed the screw to open the window, pushed the window screen, and stood up from the wheelchair and jumped off the window. During a record review of Resident 1's, Emergency Department (ED) trauma Timeline Report, dated 7/12/24, the report indicated, . Per emergency medical services (EMS) report, patient was trying to commit suicide and jumped from the second-floor balcony of her room . patient was found by a bystander who called EMS . patient endorses pain to both hips, abdomen and right lower extremity . mechanism of injury . fall from second story building. She states she wanted to commit suicide . she crawled out of her window and fell around 30 feet with loss of consciousness. Complains of abdominal and hip pain. clinical impression, closed fracture of multiple ribs of right side, laceration of liver, closed displaced subtrochanteric fracture of right femur, closed displaced intertrochanteric (the bumpy parts at the top of the thigh bone) fracture of right femur and right pneumothorax . During a record review of Resident 1's document from GACH titled, Post-Op Check, dated 7/12/2024, the document indicated, the patient stated, .I jumped out of the nursing facility that I came from because they were abusing me. They were not giving me my medicine. I begged them to give it to me, and they would not listen. So, I climbed on top of the building and jumped to try and kill myself . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of document titled, History of Present Illness, dated 7/12/2024, the record indicated the patient reported, .She was able to crawl to the window and then fell out of the window in an attempt to kill herself . On arrival to the ED, she complained of pain in her right left, lower back and abdomen During an interview on 7/15/24 at 4:15 p.m., with the facility's administrator (ADM), the ADM stated the maintenance department had verified all windows had tightly placed screws in every window of the facility. The ADM stated the facility windows should only open 2-3 inches and screws should not have been easily removable. During an observation on 7/15/24 at 4:45 p.m., the facility window screws for the second and third floor windows were observed. There were fourteen room with windows observed to have loose window screws. During an interview on 7/15/24 at 6:21 p.m., with the ADM, the ADM stated the facility's department managers and supervisors should have checked the window screws during the daily room rounds. The ADM stated it was the facility's expectation for staff to notify the maintenance department if any loose screws were observed. During a telephone interview on 7/16/24 at 11:15 a.m., with the director of staff development (DSD), the DSD stated she had provided the facility CNAs with a verbal in service regarding the use of the stop and watch and how it should have been utilized. The DSD stated she was unable to provide documentation to confirm in-service was completed. The DSD stated the facility expectation with a change of condition that included suicidal ideations was for the staff to take every statement seriously even if they are thinking in the back of their minds that the resident would not say or do something that involved suicide. The DSD stated the facility process was for the CNA who identified the change, to ensure resident safety and notify the nurse immediately for a resident assessment. The DSD stated it was not appropriate for CNA 1 to leave Resident 1 after Resident 1 was expressing thoughts of feeling like she was done. During a review of the facility's job description titled Director of Plant Maintenance, undated. The job description indicated, . principal responsibilities . ensures a safe, comfortable, sanitary environment for residents, staff, and visitors in accordance with federal, state, and corporate requirements. Performs preventative maintenance procedures . maintains equipment necessary to meet center needs . maintains written records and documents of services performed . During a record review of the facility's policy and procedure (P&P) titled Maintenance Service, dated 01/01/2012, the P&P indicated, . purpose to protect the health and safety of residents, visitors, and facility staff. Policy the maintenance department maintains all areas of the building, grounds, and equipment. Procedure, the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in compliance with current federal, state and local laws, regulations, and guidelines . maintaining the building in good repair and free from hazards, providing routinely scheduled maintenance service to all areas . the director of maintenance is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds and equipment are maintained in a safe and operable manner . the director of maintenance is responsible for maintaining the following records/reports: inspection of building . maintenance staff follow established safety regulations to ensure the safety and well-being of all concerned .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on observation interview and record review the facility failed to provide a safe environment for 28 of 134 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27 and Resident 28) when 15 resident rooms were observed to have loose window screws that were used to secure the windows in place from opening more than three inches (unit of measure) on the second and third floors of the facility. This failure placed residents in an unsafe environment which could potentially lead to an avoidable resident injury. Findings: During an interview on 7/12/24 at 8:45 a .m., with the administrator (ADM). The ADM stated that Resident 1 had opened the window in her room located on the second floor and jumped off to the ground on the first floor. The ADM stated Resident 1 was found by facility staff outside by the sidewalk. The ADM stated it appeared Resident 1 removed the protective screw from the window and pushed the window screen out to exit the window. The ADM stated Resident 1 could have used a kitchen butter knife or utensil to unscrew the window screw as the window screws should have been tightly screwed in place. The ADM stated Resident 1 was transferred to the acute hospital for further evaluation. During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis, systemic lupus erythematosus (long lasting disease that affects many parts of the body), hereditary and idiopathic neuropathy (nerve problem that causes pain, numbness, tingling, swelling or muscle weakness), spinal stenosis (causes pressure on the spinal cord or nerves), Major Depressive Disorder (mental health disorder causes persistent low or depressed mood), Borderline Personality Disorder (mental illness that causes loss of emotional control), anorexia (eating disorder that causes low body weight and intense fear of gaining weight), muscle weakness, post-traumatic stress disorder(disorder that develops when a person has experienced a scary, shocking, terrifying, or dangerous event), adult failure to thrive, homelessness, and patient noncompliance with other medical treatment and regimen due to unspecified reason. During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 6/6/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 14 out of 15 (0 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 15) cognitively intact) which indicated Resident 1 was cognitively intact. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/12/24 at 9:16 a.m., in Resident 1's room, the window was observed to have a broken window screen and a removed screw was located near the window seal. The window was observed through the glass and the window screen was noted to be out of place, bent and pushed outward. A dining table was observed against the wall under the window border. There was a window screw positioned by the window seal next to the screw hole on the window base. When the window was pulled open to the left, it was noted to open all the way through. The screen was observed outward, bent and broken. Outside the window the rooftop to the first-floor dining room was located extended out about 10 feet outward allowing a walking distance. During an interview on 7/12/24 at 12:23 p.m., with CNA 1, CNA 1 stated the screws on the windows were checked by the maintenance department and should have been screwed in place tightly and not removed easily. During an interview on 7/12/24 at 2:21 p.m., with RN 1, RN 1 stated all windows should have had a screw to lock them in place and keep them from opening more than 3-4 inches. RN 1 stated it was the maintenance department's responsibility to check all windows and screws were in place and secure. During an interview on 7/12/24 at 2:43 p.m., with RN 2, RN 2 stated the facility windows should have a screw in place to securely keep the windows from opening all the way. RN 2 stated the maintenance department checked the windows to ensure they were secure. During an interview on 7/12/24 at 2:51 p.m., with CNA 2, CNA 2 stated the facility maintenance department was in charge of ensuring windows were properly secured in all resident rooms. During a concurrent interview and record review on 7/12/24 at 3:01 pm with the Maintenance supervisor (MS), the facility's Maintenance Daily log dated 7/8/24-7/12/24 was reviewed. The log indicated, the MS was checking doors, locks & alarms, and conducting test operations for doors and locks but there was no documentation of the MS checking the windows or window screws. The MS stated the log did not indicate windows locks or security, but it was implied that they were checked daily during rounds when the facility doors were checked. The MS stated the window screws were approved by the fire marshal as appropriate for the facility. The MS stated the window screws were checked every morning during daily maintenance rounds but could not provide documentation. The MS stated all the window screws were secured in the facility and Resident 1 was able to open the window because she was actively having suicidal ideations. During an interview on 7/15/24 at 3:47 p.m., with Resident 1, Resident 1 stated she was admitted into the emergency room after she had jumped out of her window on the second floor of the facility where she resided. Resident 1 stated she had attempted to land on her head to kill herself. Resident 1 stated the suicidal ideations were a result of staff treatment in the facility where she resided but could not state the treatment she was referring to. Resident 1 stated she had thoughts of suicide previously during a stay in the GACH. Resident 1 stated that on 7/12/24 she had requested the wheelchair from the charge nurse to use the restroom, then the charge nurse proceeded to exit her room. Resident 1 stated she had observed one screw on the room window that was easily removable, removed the screw to open the window, pushed the window screen, and stood up from the wheelchair and jumped from the window. (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 1's, Emergency Department (ED) trauma Timeline Report, dated 7/12/24, the report indicated, . Per emergency medical services (EMS) report, patient was trying to commit suicide and jumped from the second-floor balcony of her room . patient was found by a bystander who called EMS . patient endorses pain to both hips, abdomen and right lower extremity . mechanism of injury . fall from second story building. She states she wanted to commit suicide . she crawled out of her window and fell around 30 feet with loss of consciousness. Complains of abdominal and hip pain. clinical impression, closed fracture of multiple ribs of right side, laceration of liver, closed displaced subtrochanteric fracture of right femur, closed displaced intertrochanteric (the bumpy parts at the top of the thigh bone) fracture of right femur and right pneumothorax . During an interview on 7/15/24 at 4:15 p.m., with the facility's administrator (ADM), the ADM stated the maintenance department had verified all windows had tightly placed screws in every window of the facility. The ADM stated the facility windows should only open 2-3 inches and screws should not have been easily removable. The ADM stated the fire marshal was in the facility and informed the facility that screwing the resident windows with screw was not allowed. During an observation on 7/15/24 at 4:45 p.m., the facility window screws for the second and third floor windows were observed. There were fourteen rooms with windows observed to have loose window screws. During an interview on 7/15/24 at 6:21 p.m., with the ADM, the ADM stated the facility's department managers and supervisors should have checked the window screws during the daily room rounds. The ADM stated it was the facility's expectation for staff to notify the maintenance department if any loose screws were observed. During a review of the facility's job description titled Director of Plant Maintenance, undated. The job description indicated, . principal responsibilities . ensures a safe, comfortable, sanitary environment for residents, staff, and visitors in accordance with federal, state, and corporate requirements. Performs preventative maintenance procedures . maintains equipment necessary to meet center needs . maintains written records and documents of services performed . During a record review of the facility's policy and procedure (P&P) titled Maintenance Service, dated 01/01/2012, the P&P indicated, . Purpose to protect the health and safety of residents, visitors, and facility staff. Policy the maintenance department maintains all areas of the building, grounds, and equipment. Procedure, the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in compliance with current federal, state and local laws, regulations, and guidelines . maintaining the building in good repair and free from hazards, providing routinely scheduled maintenance service to all areas . the director of maintenance is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds and equipment are maintained in a safe and operable manner . the director of maintenance is responsible for maintaining the following records/reports: inspection of building . maintenance staff follow established safety regulations to ensure the safety and well-being of all concerned .