STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055706	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to immediately notify the resident's Physician for one of three sampled residents (Resident 2) reviewed for accidents, of a change in condition when Resident 2 had a fall and was currently receiving anticoagulant (a group of medications that decreased your blood's ability to clot) medications. This deficient practice had the potential for Resident 2 to have complications from the use of anticoagulant due to frequent falls and not to receive the necessary interventions and negatively affect the provision of care and services. During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included history of falling, abnormalities of gait and mobility (a change to your walking pattern), and personal history of other diseases of the nervous system (a complex network of nerves and tissues that allowed us to think, feel, and move) and sense organs (parts of the body that helped us perceive the world around us including eyes for sight). During a review of Resident 2's Risk for Falls Care Plan dated 5/15/2025, the Care Plan indicated a goal for the resident to be free of falls and not sustain serious injury. The Care Plan interventions included bed in lowest position, concave mattress for special orientation, floor mats at bedside, and to place the resident in a sitter room for close observation. The Care Plan did not include the resident was legally blind. During a review of Resident 2's History and Physical (H&P) dated 5/18/2025 at 10:23 AM, the H&P indicated the resident did not have the capacity to understand and make medical decisions. The H&P indicated the resident's Head, Eyes, Ears, Nose, and Throat (HEENT, used to describe a physical examination that focused on these body systems) physical exam showed a dysconjugate gaze (a condition where the eyes did not move together in a coordinated manner, meaning they failed to move in the same direction at the same time) and Resident 2's Pupils, Equal, Round, Reactive, Light, Accommodation (PERRLA, used in medicine to describe the assessment of the pupils during a physical exam) only included PERLA. During a review of Resident 2's Anticoagulant Care Plan dated 5/19/2025, the Care Plan goals for the resident included to remain free of complications related to altered hematological status and the resident would not be re-hospitalized within 30 days. The Care Plan Interventions included to complete fall risk assessment and increase vigilance for falls, obtain and monitor lab/diagnostic work as ordered, and indicated a black box warning for Warfarin indicating the medication could cause major or fatal bleeding. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident had a fall in the last month and also had a fall in the last two to six months. During a review of Resident 2's Medication Administration Record (MAR) dated May 2025, the MAR indicated the resident was receiving Lovenox (also known as Enoxaparin sodium, to help prevent blood clots) injection solution prefilled syringe, inject 90 milligram (mg, unit of measurement) subcutaneously (beneath, or under all the layers of the skin) one time a day for deep vein thrombosis (DVT, formation of a blood clot in a deep vein, usually in the leg or arm). The MAR indicated the order date was on 5/15/2025 at 9:23 PM and the discontinue date was on 5/29/2025 at 10:19 PM. The MAR indicated Resident 2 received Lovenox from 5/18/2025 to 5/29/2025. During the same review of Resident 2's MAR dated May 2025, the MAR indicated the resident was receiving Warfarin sodium (helped prevent harmful blood clots from forming or growing larger in your body) oral tablet 7.5 mg, give one tablet by mouth in the evening for DVT for seven days. The MAR indicated the order date was on 5/22/2025 at 6:49 AM. The MAR indicated Resident 2 received Warfarin sodium from 5/22/2025 to 5/24/2025 and 5/26/2025 to 5/28/2025. The MAR indicated Resident 2 did not receive Warfarin sodium on 5/25/2025 because the resident was hospitalized . During a review of Resident 2's Change in Condition Progress Note dated 5/25/2025 at 6:53 AM, the Progress Note indicated at approximately 5:45 AM Resident 2 was seen on the floor lying face down. LVN 2 called for the Registered Nurse Supervisor to do an assessment and Resident 2 was assisted to bed in the lowest position with facility staff. During a review of Resident 2's Change in Condition Evaluation dated 5/25/2025 at 4:57 PM, the Evaluation indicated Resident 2 had a fall in the morning. The Evaluation indicated the Physician was notified at 3:30 PM with orders to send the resident to the general acute care hospital (GACH) for computed tomography (CT, a medical imaging technique that used x-rays and computer processing to create detailed cross-sectional images of the body) scan of the head due to the fall. During a review of Resident 2's Fall Risk Evaluation dated 5/25/2025 at 10:18 PM, the Fall Risk Evaluation indicated the resident had a fall risk score of 19. The Fall Risk Evaluation indicated the

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS- a resident assessment tool), accurately reflected resident's vision status for one out of three sampled residents (Resident 2), who has visual impairment (a term describing any vision loss that cannot be fully corrected). Resident 2 was assessed having adequate vision (sees fine detail, such as regular print in newspapers/books). This deficient practice had the potential for Resident 2 to not receive care to address Resident 2's visual impairment. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included history of falling, abnormalities of gait and mobility (a change to your walking pattern), and personal history of other diseases of the nervous system (a complex network of nerves and tissues that allowed us to think, feel, and move) and sense organs (parts of the body that helped us perceive the world around us including eyes for sight). During a review of Resident 2's History and Physical (H&P) dated 5/18/2025 at 10:23 AM, the H&P indicated the resident did not have the capacity to understand and make medical decisions. The H&P indicated the resident's Head, Eyes, Ears, Nose, and Throat (HEENT, used to describe a physical examination that focused on these body systems) physical exam showed a dysconjugate gaze (a condition where the eyes did not move together in a coordinated manner, meaning they failed to move in the same direction at the same time) and Resident 2's Pupils, Equal, Round, Reactive, Light, Accommodation (PERRLA, used in medicine to describe the assessment of the pupils during a physical exam) only included PERLA. During a review of Resident 2's Minimum Data Set, dated [DATE], signed by MDS Nurse (MN), indicated the resident has severely impaired cognition (a person's ability to think, learn, remember, use judgement, and make decisions). The MDS also indicated that the resident did not exhibit disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). The MDS indicated that the resident is dependent (helper does all the effort) on activities of daily living, including eating, hygiene, and bathing. The MDS indicated the resident requires substantial assistance (helper does more than half the effort) on activities such as rolling in bed from left to right, changing positions from sitting to lying in bed, lying in bed to sitting, and sitting to standing. The MDS also indicated that the resident was assessed to have adequate vision (sees fine detail, such as regular print in newspapers/books). The MDS also indicated the resident did not wear corrective lenses such as contacts, glasses, or magnifying glass, and never needed someone to help when reading instructions, pamphlets, or other written material from the doctor or pharmacy During a review of Resident 2's Occupational Therapy Evaluation (OTE) from General Acute Care Hospital (GACH) prior to the admission to the facility, included the following evaluation notes regarding Resident 2's vision: Dated 5/13/2025, Spontaneously tracks laterally but no visual tracking, No consistent blink to threat; and Dated 5/6/2025, Impaired visual foundation skills, impaired visual perceptual skills. During a review of Resident 2's Initial admission Record (IAR), dated 5/15/2025, timed at 10:20 PM, signed by a Registered Nurse (RN), indicated the following regarding Resident 2's vision. The IAR indicated Resident 2's ability to see adequate light (with glasses or other visual appliances) was impaired (sees large print but no regular print in newspaper/books). The IAR also indicated the resident does not wear corrective lenses. The IAR also added that corrective lenses were present during the resident's admission. During a review of Resident 2's Occupational Therapy OT Evaluation & Plan of Treatment, dated 5/16/2025, signed by Occupational Therapist (OTR), included precautions for Resident 2 including risk of falls and bilateral eye blindness. During a review of Resident 2's Optometric Notes, dated 5/24/2025, the notes indicated there was suspicion that Resident 2 was blind. The notes added the resident mentioned to facility staff that I (Resident 2) can't see. The notes indicated that Resident 2 has a problem of Cortical blindness (a condition where vision loss is caused by damage to the visual processing areas of the brain). During an observation and interview on 7/11/2025 at 8:48 AM inside Resident 2's room bathroom, Resident 2 was approached for an interview. Resident 2 stood 2 feet facing the surveyor but did not look into the surveyor's eyes when responding to questions. During the interview, Resident 2 stated her eyesight is blurry and could not see the surveyor's face. Resident 2 stated she was only able to see shapes but could not distinguish details. Resident 2 stated she cannot read anything that is put in front of her regardless of distance. During an interview on 7/11/2025 at 9:05 AM with Resident 2's assigned Certified Nursing Assistant (CNA), CNA 1 stated Resident 2 requires help with walking to the bathroom because of her vision. CNA 1 stated Resident 2

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered plan of care for one out of three sampled residents (Resident 2) who was assessed to have visual impairment (a term describing any vision loss that cannot be fully corrected) did not have a care plan to address interventions for the resident's visual impairment. This deficient practice had the potential for Resident 2 not to receive care and services for visual impairment such as keeping the resident safe and to prevent accidents and falls. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included history of falling, abnormalities of gait and mobility (a change to your walking pattern), and personal history of other diseases of the nervous system (a complex network of nerves and tissues that allowed us to think, feel, and move) and sense organs (parts of the body that helped us perceive the world around us including eyes for sight). During a review of Resident 2's History and Physical (H&P) dated 5/18/2025 at 10:23 AM, the H&P indicated the resident did not have the capacity to understand and make medical decisions. The H&P indicated the resident's Head, Eyes, Ears, Nose, and Throat (HEENT, used to describe a physical examination that focused on these body systems) physical exam showed a deconjugate gaze (a condition where the eyes did not move together in a coordinated manner, meaning they failed to move in the same direction at the same time) and Resident 2's Pupils, Equal, Round, Reactive, Light, Accommodation (PERRLA, used in medicine to describe the assessment of the pupils during a physical exam) only included PERLA. During a review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/20/2025, the MDS indicated the resident had severe impaired cognition (the ability to think, learn, remember, use judgement, and make decisions). The MDS indicated that the resident is dependent (helper does all the effort) on activities of daily living, including eating, hygiene, and bathing. The MDS indicated the resident requires substantial assistance (helper does more than half the effort) on activities such as rolling in bed from left to right, changing positions from sitting to lying in bed, lying in bed to sitting, and sitting to standing. The MDS also indicated that the Resident 2 was assessed to have adequate vision (sees fine detail, such as regular print in newspapers/books). The MDS indicated the resident had a fall in the last month and in the last two to six months. During a review of Resident 2's Fall Risk Evaluation dated 5/24/2025 at 3:36 PM, the Fall Risk Evaluation indicated the resident had a fall risk score of 18 and was at high risk for falls. The Fall Risk Evaluation indicated the resident had a history of one to two falls in the past three months, was regularly incontinent (involuntary loss of bodily fluids, such as urine or stool), and was legally blind. During a review of Resident 2's Fall Risk Evaluation dated 5/25/2025 at 10:18 PM, the Fall Risk Evaluation indicated the resident had a fall risk score of 19 and was at high risk for falls. The Fall Risk Evaluation indicated the resident was disoriented times three, had a history of one to two falls in the past three months, was regularly incontinent, and was legally blind. During a review of Resident 2's Fall Risk Evaluation dated 6/7/2025 at 11:39 AM, the Fall Risk Evaluation indicated the resident had a fall risk score of 22 and was at high risk for falls. The Fall Risk Evaluation indicated the resident was disoriented times three, had three or more falls in the past three months, was regularly incontinent, and was legally blind. During a review of Resident 2's Occupational Therapy Evaluation (OTE) from General Acute Care Hospital (GACH) prior to the admission to the facility, included the following evaluation notes regarding Resident 2's vision: Dated 5/13/2023, Spontaneously tracks laterally but no visual tracking, No consistent blink to threat; and Dated 5/6/2025, Impaired visual foundation skills, impaired visual perceptual skills. During a review of Resident 2's Initial admission Record (IAR), dated 5/15/2025, timed at 10:20 PM, signed by a Registered Nurse (RN), indicated the following regarding Resident 2's vision. The IAR indicated Resident 2's ability to see adequate light (with glasses or other visual appliances) was impaired (sees large print but no regular print in newspaper/books). The IAR also indicated that the resident does not wear corrective lenses. The IAR also added that corrective lenses were present during the resident's admission. During a review of Resident 2's Occupational Therapy OT Evaluation & Plan of Treatment, dated 5/16/2025, signed by Occupational Therapist (OTR), included precautions for Resident 2 including risk of falls and bilateral eye blindness. During a review of Resident 2's Optometric Notes, dated 5/24/2025, the notes indicated that there was suspicion that Resident 2 was blind. The notes added the resident (Resident 2) mentioned to facility staff that I (Resident 2) can't see. The notes indicated that Resident 2 has a problem of Cortical blindness (a condition where vision loss is caused by

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fall prevention interventions were implemented for one out of three sampled residents (Resident 2), reviewed for accidents when Resident 2, who had history of multiple falls at the facility (5/24/2025, 5/25/2025, 6/7/2025, and 6/10/2025), did not have a floor mat in place when the resident was lying in bed, as indicated in the resident's care plan titled Actual Fall. This deficient practice had the potential for recurrent falls for Resident 2 and sustain major injuries as a result of a fall from the resident's bed. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included history of falling, abnormalities of gait and mobility (a change to your walking pattern), and personal history of other diseases of the nervous system (a complex network of nerves and tissues that allowed us to think, feel, and move) and sense organs (parts of the body that helped us perceive the world around us including eyes for sight). During a review of Resident 2's History and Physical (H&P) dated 5/18/2025 at 10:23 AM, the H&P indicated the resident did not have the capacity to understand and make medical decisions. The H&P indicated the resident's Head, Eyes, Ears, Nose, and Throat (HEENT, used to describe a physical examination that focused on these body systems) physical exam showed a dysconjugate gaze (a condition where the eyes did not move together in a coordinated manner, meaning they failed to move in the same direction at the same time) and Resident 2's Pupils, Equal, Round, Reactive, Light, Accommodation (PERRLA, used in medicine to describe the assessment of the pupils during a physical exam) only included PERLA. During a review of Resident 2's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/20/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident's ability to see in adequate light with glasses or other visual appliances was adequate, meaning the resident was able to see fine detail, such as regular print in newspapers/books, did not wear corrective lenses such as contacts, glasses, or magnifying glass, and never needed someone to help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. The MDS indicated the resident had a fall in the last month and also had a fall in the last two to six months. During a review of Resident 2's Fall Risk Evaluation dated 5/24/2025 at 3:36 PM, the Fall Risk Evaluation indicated the resident had a high fall risk score of 18. The Fall Risk Evaluation indicated the resident was disoriented times three (a resident who is alert but disoriented to person, place, and time), had a history of one to two falls in the past three months, was regularly incontinent (involuntary loss of bodily fluids, such as urine or stool), and was legally blind. The Fall Risk Evaluation indicated the resident had a balance problem while standing/walking, required use of assistive devices, and had one to two predisposing diseases (having a higher chance of developing a disease due to inherited genetic factors or family history) present. During a review of Resident 2's second Fall Risk Evaluation dated 5/25/2025 at 10:18 PM, the Fall Risk Evaluation indicated the resident had a higher fall risk score of 19. The Fall Risk Evaluation indicated the resident was disoriented times three, had a history of one to two falls in the past three months, was regularly incontinent, and was legally blind. The Fall Risk Evaluation indicated the resident required use of assistive devices, was taking one to two medications, and had one to two predisposing diseases present. During a review of Resident 2's third Fall Risk Evaluation dated 6/7/2025 at 11:39 AM, the Fall Risk Evaluation indicated the resident had a higher fall risk score of 22. The Fall Risk Evaluation indicated the resident was disoriented times three, had three or more falls in the past three months, was regularly incontinent, and was legally blind. The Fall Risk Evaluation indicted the resident had a balance problem while standing/walking, required used of assistive devices, was taking one to two medications, and had one to two predisposing diseases present. During a review of Resident 2's Fall Risk Evaluation dated 6/10/2025 at 3:56 AM, the Fall Risk Evaluation indicated the resident had a fall risk score of back to 18. The Fall Risk Evaluation indicated the resident was disoriented times three, had one to two falls in the past three months, was regularly incontinent, and had adequate vision with or without glasses. The Fall Risk Evaluation indicated the resident had a balance problem while standing/walking, required use of assistive devices, was taking three to four medications, and had one to two predisposing diseases present. During a review of Resident 2's care plan for falls, initiated on 5/15/2025, the care plan included an intervention to have the resident's bed on the lowest position with a floor mat for poor safety awareness. During a review of Resident 2's care plan for Actual Fall, initiated on 6/10/2025, included

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accurately document in the Fall Risk Evaluation (FRE) on 6/10/2025 and accurately document in the Minimum Data Set (MDS, a federally mandated resident assessment tool) that one of three samples residents (Resident 2) had visual impairment (a term describing any vision loss that cannot be fully corrected) and was at high risk for accidents and fall due to blindness. This deficient practice had the potential for Resident 2 not to receive care to address Resident 2's visual impairment that could lead to a lack of or delay in delivery of necessary care or services to Resident 2 such as monitoring and supervision to prevent recurrent accidents and falls.Findings: During a review of Resident 2's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included history of falling, abnormalities of gait and mobility (a change to your walking pattern), and personal history of other diseases of the nervous system (a complex network of nerves and tissues that allowed us to think, feel, and move) and sense organs (parts of the body that helped us perceive the world around us including eyes for sight). During a review of Resident 2's Risk for Falls Care Plan dated 5/15/2025, the Care Plan indicated a goal for the resident to be free of falls and not sustain serious injury. The Care Plan interventions included bed in lowest position, concave mattress for special orientation, floor mats at bedside, and to place the resident in a sitter room for close observation. The Care Plan did not indicate Resident 2 was legally blind and at risk for accidents and fall due to blindness or impaired vision. During a review of Resident 2's Initial admission Record (IAR), dated 5/15/2025 at 10:20 PM, signed by a Registered Nurse (RN), indicated Resident 2's ability to see adequate light (with glasses or other visual appliances) was impaired (sees large print but no regular print in newspaper/books). The IAR also indicated that the resident did not wear corrective lenses. The IAR also added that corrective lenses were present during the residents' admission. During a review of Resident 2's Occupational Therapy OT Evaluation & Plan of Treatment, dated 5/16/2025, signed by the Occupational Therapist (OTR), included precautions for Resident 2 including risk of falls and bilateral eye blindness. During a review of Resident 2's History and Physical (H&P) dated 5/18/2025 at 10:23 AM, the H&P indicated the resident did not have the capacity to understand and make medical decisions. The H&P indicated the resident's Head, Eyes, Ears, Nose, and Throat (HEENT, used to describe a physical examination that focused on these body systems) physical exam showed a dysconjugate gaze (a condition where the eyes did not move together in a coordinated manner, meant they failed to move in the same direction at the same time) and Resident 2's Pupils, Equal, Round, Reactive, Light, Accommodation (PERRLA, used in medicine to describe the assessment of the pupils during a physical exam) only included PERLA. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident's ability to see in adequate light with glasses or other visual appliances was adequate, meaning the resident was able to see fine details, such as regular print in newspapers/books, did not wear corrective lenses such as contacts, glasses, or magnifying glass, and never needed someone to help when reading instructions, pamphlets, or other written material from the doctor or pharmacy. The MDS indicated the resident had a fall in the last month and also had a fall in the last two to six months. The MDS did not indicate Resident 2 was legally blind. During a review of Resident 2's Optometric Notes, dated 5/24/2025, the note indicated that there was suspicion that Resident 2 was blind. The note added the resident mentioned to facility staff that I (Resident 2) can't see. The note indicated that Resident 2 had a problem of Cortical blindness (a condition where vision loss is caused by damage to the visual processing areas of the brain). During a review of Resident 2's Change in Condition Evaluation dated 5/24/2025 at 2:19 PM, the Evaluation indicated Resident 2 had a witnessed fall in the morning. During a review of Resident 2's Fall Risk Evaluation dated 5/24/2025 at 3:36 PM, the Fall Risk Evaluation indicated the resident had a fall risk score of 18. During a review of Resident 2's Change in Condition Evaluation dated 5/25/2025 at 4:57 PM, the Evaluation indicated Resident 2 had a fall in the morning and was ordered by the physician to be sent to hospital for computed tomography (CT, a medical imaging technique that used x-rays and computer processing to create detailed cross-sectional images of the body) scan of the head due to the fall. During a review of Resident 2's Fall Risk Evaluation dated 5/25/2025 at 10:18 PM, the Fall Risk Evaluation indicated the resident had a fall risk score of 19. During a review of Resident 2's Change in Condition Evaluation dated 6/7/2025 at 9:30 AM, the Evaluation