STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056007	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Care Nursing Center	3355 Pacific Place Long Beach, CA 90806

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 - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was not moved following a fall from the bed to the floor. The facility failed to:1.Ensure Certified Nursing Assistant (CNA) 1 and facility staff safely cared for Resident 1 by leaving him in place on the floor until paramedics arrived, as required for suspected head, neck, or spinal injuries after a fall on 5/2/2026.2.Ensure staff followed Resident 1's Care Plan titled At Risk for Fractures initiated 2/12/2026, which indicated, the facility must minimize the risk for fracture (broken bone) by assessing for possible risks sustain a fracture such as unsafe transfers.3.Ensure staff followed the facility's policy and procedure (P&P) titled Falls by a Resident, revised 7/2017, which directed staff not to move a resident after a fall until assessed by a licensed nurse.These failures resulted in improper movement of Resident 1after falling from the bed to the floor on 5/2/2026 at approximately 5:30 p.m., Resident 1 sustained right periorbital (eyelid and the soft skin around eye) swelling, and bruising (skin discoloration) with acute skin tears (a sudden accidental scrape or cut where the top layers of your skin peel back) to the upper extremity (arms and hands). Resident 1 was transferred to a general acute care hospital (GACH) for evaluation and treatment via 911 on 5/2/2026 at approximately 6:15 p.m. Resident 1 sustained multiple injuries, including a left parietal (part of the brain) subdural hematoma (a serious medical condition where blood pools between the brain and the skull, specifically in the upper-middle section of the head), right transverse process fracture (broken bone in one of the tiny, wing-like bumps on the side of spine's bones), of Cervical neck (C1) and right humeral head (upper arm bone) dislocation (when bones are pulled out of the normal position like the shoulder or finger) and fracture (broken bone at the top of the upper arm), a left seventh (7th) rib fracture, and a right femoral neck fracture, (a broken bone in the hip, right at the narrow neck of the thigh bone). Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic respiratory failure (develops when the lungs cannot get enough oxygen into the blood) dependent on respirator (a medical device to help support or replace breathing), tracheostomy (a surgically created hole in the neck leading directly into the windpipe, to help a resident breathe), and contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of both lower leg.During a review of Resident 1's Care Plan titled At Risk for Fracture, initiated on 2/12/2026, the Care Plan indicated Resident 1 was high risk for fracture related to contractures poor safety awareness, and cognitive impairment. The Care Plan goal indicated the facility will minimize the risk of fracture. The Care Plan interventions included to always handle Resident 1 gently and carefully, maintain his bed in lowest position, and provide one to two-person assist with Activities of Daily Living (ADLs- activities such as bathing, dressing, toileting a person performs daily).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/2/2026, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 was dependent with ADLs and roll (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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(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 - Few	left and right (ability to roll from lying on back to left and right side, and return to lying on back on the bed)During a review of Resident 1's Emergency Medical Services (EMS- team of trained professionals who provide immediate medical care and transport to a hospital when 911 is called) Run Sheet dated 5/2/2026 at 6:01 p.m., the Paramedic Run Sheet indicated Resident 1 was observed sitting in hospital bed. EMS Run Sheet indicated facility staff were changing Resident 1's incontinent brief (diaper) when Resident 1 rolled out of the bed onto the floor. The Paramedic Run Sheet indicated Resident 1 had an abrasion (superficial wound), and a hematoma (localized collection of blood) to the top of his head, swelling and bruising to his right eye.During a review of Resident 1's GACH 1 Emergency Documentation (ED) Physician Note dated 5/2/2026 at 6:51 p.m., the note indicated upon EMS arrival to Resident 1's room, Resident 1 was back in bed and it was unknown how Resident 1 fell given that he did not have a range of mobility (the ability to move freely and independently) at baseline. The Note indicated contrary to nursing home report to EMS, staff informed MD 1 that the resident was accidentally dropped during cleaning.During a review of Resident 1's GACH 1 Emergency Documentation dated 5/3/2026 at 12:14 a.m., the Note indicated Resident 1 had a left subdural hematoma, fracture of the right transverse process of cervical neck which was immobilized (held in place to restrict movement) with a cervical collar (a device used to support the head, immobilize the neck, and limit movement), right shoulder fracture and dislocation, supported in sling (device used to immobilize, and protect an injured arm and shoulder) and left seventh rib fracture. The note indicated attempts to reduce Resident 1's shoulder dislocation was unsuccessful, and the resident was transferred to GACH 2 for higher level of care (more intensive medical treatment).During an interview on 5/8/2026 at 11:48 a.m., with Respiratory Therapist (RT) 1, RT 1 stated when he walked into Resident 1's room after the fall on 5/2/2026, he saw Resident 1 lying on his side while CNA 1 held his head and applied pressure to his forehead. RT 1 stated after RN 1 assessed Resident 1, they rolled him from side to side to place a sheet underneath him and then used the sheet to lift him and return him to the bed.During an interview on 5/8/2026 at 12:48 p.m., with Registered Nurse (RN) 2, RN 2 stated when Resident 1 fell from the bed to the floor, staff should have left him on the floor until the paramedics arrived. RN 2 stated Resident 1 could have had fractures or internal bleeding and moving him could have caused further harm. RN 2 stated Resident 1 had bruising around his eye and a forehead laceration (a rough, tear or cut in the skin and underlying soft tissues, usually caused by blunt trauma [forceful impact]) , which could have resulted from blunt force trauma and required evaluation at the GACH to rule out internal injuries. RN 2 stated it was a common nursing practice not to move a resident when a neck or head injury was suspected.During an interview on 5/8/2026 at 2:06 p.m., with the Director of Staff Development (DSD), the DSD stated CNAs were trained not to move residents after a fall and to wait for the nurse. The DSD stated it was important for CNAs to avoid moving residents after a fall because they did not know whether the resident had injuries, and moving the resident could worsen those injuries and cause further harm.During a phone interview on 5/8/2026 at 3:59 p.m., with Registered Nurse (RN) 1, RN 1 stated when she entered Resident 1's room after he fell, she found him lying face down on his stomach while CNA 1 applied pressure to his forehead. RN 1 stated staff rolled Resident 1 onto his left side to assess him. She stated he had swelling and discoloration around his right eye and an open cut on his forehead which could be a serious head injury. RN 1 stated she believed it was safe to move Resident 1 from the floor back into bed because she completed a neurological assessment (a painless brain and body checkup used to see how well a person's brain, and body are working) and felt he was okay. RN 1 stated Resident 1 remained calm and did not show any signs of pain, discomfort, or restlessness (inability to sit still or relax).During a follow-up interview on 5/8/2026 at 4:47 p.m., with CNA 1. CNA 1 stated she moved Resident 1 from lying on his stomach so she could place her hand under his head and apply pressure with a towel to his bleeding forehead. CNA 1 stated after RN 1 assessed Resident 1, she and three other staff members rolled him from side to side to place a linen sheet underneath him. CNA 1 stated once the linen sheet was in place, each staff member grabbed a corner of the linen sheet and lifted (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 back into the bed. CNA 1 stated RN 1 told them it was safe to move Resident 1 back into bed, which was why they lifted him.During a review of the facility's policy and procedure (P&P) titled, Falls by a Resident, revised 7/2017, the P&P indicated, When a resident sustains a fall, the licensed nurse is to be notified immediately and the resident is not to be moved until assessed by the licensed nurse.Cross Reference F689

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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	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** Based on interview and record review, the facility failed to ensure residents, at high risk for falls and injuries, received fallˆprevention interventions for one of three sampled residents (Resident 1).The facility failed to:1.Ensure Certified Nursing Assistant (CNA) 1 was aware of Resident 1's high fall-risk status.2. Ensure Resident 1's physician (MD) orders dated 2/12/2026 for fallˆprevention devices including floor mats (cushioned pads placed on the floor besides a resident's bed to decrease the impact of a fall) and bilateral bolsters (firm, padded foam cushions placed along the sides of a bed to act as soft, safe bumpers to prevent residents from rolling out of bed) were not discontinued on 2/13/2026, despite Resident 1 continuing to be assessed as high risk for falls and injuries.3. Implemented Resident 1's care plan titled High Risk for Injury, initiated 2/12/2026, which indicated staff will provide a safe environment for the resident to prevent injuries.4. Follow its policy and procedure (P&P) titled Fall Risk & Prevention of Injury to Include Pathological Fractures (broken bone that occurs in an area weakened by an underlying disease or condition), revised 3/2019, which indicated the facility will provide floor mats at residents' bedside to prevent falls and/or fractures (broken bone).As a result of these failures Resident 1 fell from the bed to the floor on 5/2/2026, sustained multiple injuries, including a left parietal (part of the brain) subdural hematoma (a serious medical condition where blood pools between the brain and the skull, specifically in the upper-middle section of the head), right transverse process fracture (broken bone in one of the tiny, wing-like bumps on the side of spine's bones), of Cervical (C1-neck) and right humeral head (upper arm bone) dislocation (when bones are pulled out of the normal position like the shoulder or finger) and fracture (broken bone at the top of the upper arm), a left seventh (7th) rib fracture, and a right femoral neck fracture, (a broken bone in the hip, right at the narrow neck of the thigh bone), right periorbital (eyelid and the soft skin around eye) swelling, and bruising (skin discoloration) with acute skin tears (a sudden accidental scrape or cut where the top layers of your skin peel back) to the upper extremity (arms and hands), and with bilateral pleural effusions (when extra fluid is trapped in the lining around both lungs). Resident 1 was transferred to two general acute care hospitals (GACH 1 and 2) for evaluation and treatment. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic respiratory failure (develops when the lungs cannot get enough oxygen into the blood) dependent on respirator (a medical device to help support or replace breathing), tracheostomy (a surgically created hole in the neck leading directly into the windpipe, to help a resident breathe), and contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of both lower leg.During a review of Resident 1's Care Plan titled High Risk for Injury, initiated on 2/12/2026, the Care Plan indicated Resident 1 was identified to be a high risk for injury related to poor safety awareness, dementia (a progressive state of decline in mental abilities), and encephalopathy. The Care Plan goal indicated Resident 1 would have no injury for three months. The Care Plan interventions included implementing fall precautions and provided a safe environment for the resident.During a review of Resident 1's Care Plan titled At Risk for Falls and Injuries initiated on 2/12/2026, the Care Plan indicated Resident 1 was a high risk for falls related to general weakness, encephalopathy, cognitive decline (inability to think, understand, learn, and remember) and restlessness. The Care Plan goal indicated the facility will minimize the risk of falls. The Care Plan interventions indicated the facility will provide fall precaution interventions for Resident 1.During a review of Resident 1's Care Plan titled At Risk for Fracture, initiated on 2/12/2026, the Care Plan (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	indicated Resident 1 was high risk for fracture related to contractures (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) poor safety awareness, and cognitive impairment. The Care Plan goal indicated the facility will minimize the risk of fracture. The Care Plan interventions included to always handle Resident 1 gently and carefully, maintain his bed in lowest position, and provide one to two-person assist with Activities of Daily Living (ADLs- activities such as bathing, dressing, toileting a person performs daily).During a review of Resident 1's Order Details dated 2/12/2026, the Order Details indicated bilateral floor mats and bilateral bolsters for added safety.During a review of Resident 1's Order Details 2/13/2026, the Order Details indicated the bilateral floor mats and bilateral bolster were discontinued.During a review of Resident 1's Licensed Personnel Progress Notes dated 2/13/2026, Progress Notes indicated Resident 1 did not require the use of bolster and floor mats because the resident did not move and was dependent (helper does all the effort and assistance of two or more helpers was required) on staff for mobility.During a review of Resident 1's Fall Risk Evaluation dated 3/2/2026, the Fall Risk Evaluation indicated Resident 1 was at high fall risk.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/2/2026, the MDS indicated Resident 1's cognition was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort. Assistance of two or more helpers is required to complete the activity) with ADLs and roll left and right (ability to roll from lying on back to left and right side, and return to lying on back on the bed)During a review of Resident 1's Emergency Medical Services (EMS- team of trained professionals who provide immediate medical care and transport to a hospital when 911 is called) Run Sheet dated 5/2/2026 at 6:01 p.m., the Paramedic Run Sheet indicated Resident 1 was observed sitting in hospital bed. EMS Run Sheet indicated facility staff were changing Resident 1's incontinent brief (diaper) when Resident 1 rolled out of the bed onto the floor. The Paramedic Run Sheet indicated Resident 1 had an abrasion (superficial wound), and a hematoma (localized collection of blood) to the top of his head, swelling and bruising to his right eye.During a review of Resident 1's GACH 1 Emergency Documentation (ED) Physician Note dated 5/2/2026 at 6:51 p.m., the note indicated upon EMS arrival to Resident 1's room, Resident 1 was back in bed and it was unknown how Resident 1 fell given that he did not have a range of mobility (the ability to move freely and independently) at baseline. The Note indicated contrary to nursing home report to EMS, staff informed MD 1 that the resident was accidentally dropped during cleaning.During a review of Resident 1's GACH 1 Emergency Documentation dated 5/3/2026 at 12:14 a.m., the Note indicated Resident 1 had a left subdural hematoma, fracture of the right transverse process of cervical neck which was immobilized (held in place to restrict movement) with a cervical collar (a device used to support the head, immobilize the neck, and limit movement), right shoulder fracture and dislocation, supported in sling (device used to immobilize, and protect an injured arm and shoulder) and left seventh rib fracture. The note indicated attempts to reduce Resident 1's shoulder dislocation were unsuccessful, and the resident was transferred to GACH 2 for higher level of care (more intensive medical treatment).During a review of Resident 1's GACH 2's History of Present Illness report dated 5/3/2026, the report indicated Resident 1 was transferred from GACH 1 for higher level of care following a fall which resulted in injuries at a facility, where the resident resided. The report indicated Resident 1 had a left parietal subdural hematoma, right transverse process fracture of cervical neck and right humeral head dislocation and fracture, a left 7th rib fracture, and a right femoral neck fracture, right periorbital swelling, and bruising, with acute skin tears to his upper extremity, and bilateral pleural effusions. Resident 1 was hypotensive (low blood pressure), on two vasopressors (lifesaving medications used when patient's blood pressure drops to dangerous or fatal levels). The report indicated Resident 1 was admitted to the intensive care unit ([ICU- specialized hospital department that provides round-the-clock monitoring and life support for patients with life-threatening injuries). The report indicated neurosurgery (medical specialty that focuses on diagnosing and treating conditions that affect the brain, spine, and nervous system) and orthopedic surgery (medical specialty (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that focuses on the diagnosis, treatment of injuries of the bones) were consulted and both determined Resident 1 was not a candidate for any surgical intervention. Resident 1's right upper extremity was stabilized with a sling.During a phone interview on 5/7/2026 at 3:54 p.m., with CNA 1, CNA 1 stated Resident 1 did not roll from side to side on his own. CNA 1 stated on 5/2/2026, after she finished changing Resident 1's incontinent brief (diaper), she centered Resident 1 in the middle of the bed, turned him onto his left side, placed a wedge (a triangular, firm foam cushion used to support the body in bed) behind his back, and positioned a pillow between his legs to keep him in place. CNA 1 stated she lowered the bed to the lowest position and, when she turned her back to dump the dirty linens into the cart at the entrance of the room, she heard a thump (dull sound made by something falling or hit something with a heavy blow), turned around, and saw Resident 1 on the floor, lying face down on his stomach. CNA 1 stated no floor mats or bolsters were in place at the time of the fall and that Resident 1 should have had floor mats because he was frail (physically weak; delicate, or not very healthy).During an interview on 5/7/2026 at 4:06 p.m., with CNA 2, CNA 2 stated Resident 1 was unable to move on his own and required assistance to move from side to side because he was contracted. CNA 2 stated Resident 1 did not have a floor mat or side rails. CNA 2 stated Resident 1 should have had side rails and floor mats in place for his safety, to prevent falls or injuries, and because he wiggled in bed.During a phone interview on 5/8/2026 at 3:59 p.m., with Registered Nurse (RN) 1, RN 1 stated when she entered Resident 1's room after the fall, she found him lying face down on his stomach. RN 1 stated he did not show signs of pain or discomfort and was not agitated or restless. RN 1 stated Resident 1 was a high fall risk and his interventions included keeping his bed low and performing visual checks. RN 1 stated if floor mats had been in place, that would have reduced the impact of the fall and the severity of Resident 1's injuries.During an interview on 5/8/2026 at 4:47 p.m. with CNA 1 in Resident 1's room, CNA 1 stated she was not aware Resident 1 was a high fallˆrisk. CNA 1 stated not knowing this information could lead staff to fail to implement appropriate fallˆprevention interventions such as ensuring floor mats were in place and calling for help during care. CNA 1 stated Resident 1 was at risk for falls and injuries.During a concurrent interview and record review on 5/11/2026 at 10:46 a.m., with the Director of Nursing (DON), Resident 1's Progress Notes dated 2/12/2026 was reviewed. The note indicated Resident 1 did not require the use of bolsters and floor mats because the resident did not move and was dependent on staff for mobility. The DON stated Resident 1 had contractures in both lower legs, limited movement in his right arm, and weakness in his left arm. The DON stated Resident 1 was unable to move or turn himself and required maximum assistance for moving, turning, and rolling. The DON stated Resident 1's fall risk score from 3/2026 was 16, indicating a high fall risk.During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 2/2019, the P&P indicated, It is the policy of the facility to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.During a review of the facility's P&P titled, Fall Risk & Prevention of Injury to Include Pathological Fractures, revised 3/2019, the P&P indicated, Approaches to prevent falls and/or fractures may include providing floor mats at the bedside.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nursing staff had specific competencies and skills sets necessary to care for one of three sampled residents (Resident 1) needs by failing to:1.Ensure Certified Nurse Assistant (CNA) 1 did not move Resident 1 onto his left side after he fell from the bed to the floor.2.Ensure the nursing staff did not move Resident 1 from the floor back to the bed after Resident 1 fell and sustained a forehead laceration (a rough, tear or cut in the skin and underlying soft tissues, usually caused by blunt trauma [forceful impact]) and bruising his face.3.Ensure CNA 1 was aware of Resident 1's high fall risk status.This failure had the potential to place Resident 1 and other residents at risk for increased harm of unknown internal injuries from the fall.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE]. Resident 1's diagnoses included encephalopathy (any disease, damage, or malfunction that affects the brain's structure or function), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), chronic respiratory failure (develops when the lungs cannot get enough oxygen into the blood) dependent on respirator (a medical device to help support or replace breathing), tracheostomy (a surgically created hole in the neck leading directly into the windpipe, to help a resident breathe), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and contracture (a permanent tightening of muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) of both lower leg.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 3/2/2026, the MDS indicated Resident 1's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 1 was dependent (helper does all the effort) with activities of daily living (ADLs- routine tasks such as bathing, dressing, and toileting a person performs daily to care for themselves) and roll left and right (ability to roll from lying on back to left and right side, and return to lying on back on the bed).During a review of Resident 1's Fall Risk Evaluation dated 3/2/2026, the Fall Risk Evaluation indicated Resident 1 was at high fall risk.During a review of Resident 1's Emergency Medical Services (EMS- team of trained professionals who provide immediate medical care and transport to a hospital when 911 is called) Run Sheet dated 5/2/2026 at 6:01 p.m., the Paramedic Run Sheet indicated Resident 1 was observed sitting in hospital bed. EMS Run Sheet indicated facility staff were changing Resident 1's incontinent brief (diaper) when Resident 1 rolled out of the bed onto the floor. The Paramedic Run Sheet indicated Resident 1 had an abrasion (superficial wound), and a hematoma (localized collection of blood) to the top of his head, swelling and bruising to his right eye.During a review of Resident 1's GACH 1 Emergency Documentation (ED) Physician Note dated 5/2/2026 at 6:51 p.m., the note indicated upon EMS arrival to Resident 1's room, Resident 1 was back in bed and it was unknown how Resident 1 fell given that he did not have a range of mobility (the ability to move freely and independently) at baseline. The Note indicated contrary to nursing home report to EMS, staff informed MD 1 that the resident was accidentally dropped during cleaning.During a review of Resident 1's GACH 1 Emergency Documentation dated 5/3/2026 at 12:14 a.m., the Note indicated Resident 1 had a left subdural hematoma (a serious medical condition where blood pools between the brain and the skull, specifically in the upper-middle section of the head), fracture of the right transverse process (broken bone in one of the tiny, wing-like bumps on the side of spine's bones) of cervical neck which was immobilized (held in place to restrict movement) with a cervical collar (a device used to support the head, immobilize the neck, and limit movement), right shoulder fracture and dislocation (when bones are pulled out of the normal position like the shoulder or finger), supported in sling (device used to immobilize, and protect an injured arm and shoulder) and left seventh rib fracture. The note (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated attempts to reduce Resident 1's shoulder dislocation was unsuccessful, and the resident was transferred to GACH 2 for higher level of care (more intensive medical treatment).During a phone interview on 5/7/2026 at 3:54 p.m., with CNA 1, CNA 1 stated Resident 1 did not roll from side to side on his own. CNA 1 stated on 5/2/2026, after she finished changing Resident 1's incontinent brief (diaper), she centered Resident 1 in the middle of the bed, turned him onto his left side, placed a wedge (a triangular, firm foam cushion used to support the body in bed) behind his back, and positioned a pillow between his legs to keep him in place. CNA 1 stated she lowered the bed to the lowest position and, when she turned her back to dump the dirty linens into the cart at the entrance of the room, she heard a thump (dull sound made by something falling or hit something with a heavy blow), turned around, and saw Resident 1 on the floor, lying face down on his stomach. CNA 1 stated no floor mats or bolsters were in place at the time of the fall and that Resident 1 should have had floor mats because he was frail (physically weak; delicate, or not very healthy).During an interview on 5/8/2026 at 11:48 a.m. with Respiratory Therapist (RT) 1, RT 1 stated when he entered Resident 1's room after the fall on 5/2/2026, Resident 1 was lying on his side, and CNA 1 was supporting the resident's head with one hand while applying pressure to his forehead with the other. RT 1 stated after Registered Nurse Supervisor (RNS) 1 assessed Resident 1, they rolled the resident from side to side to place a sheet underneath him and then used the sheet to lift Resident 1 back onto the bed.During an interview on 5/8/2026 at 12:48 p.m. with Registered Nurse Supervisor (RNS) 2, RNS 2 stated when Resident 1 fell from the bed to the floor, the resident should have been left on the floor until paramedics arrived. RNS 2 stated Resident 1 could have had fractures or internal bleeding, and moving him could have caused further harm. RNS 2 stated Resident 1 had bruising around his eye and a laceration on his forehead, which could indicate blunt force trauma (physical injury caused by a forceful impact) and required evaluation at the general acute care hospital (GACH) to rule out internal injuries. RNS 2 stated it was common nursing practice not to move a resident when a head or neck injury was suspected.During an interview on 5/8/2026 at 2:06 p.m. with the Director of Staff Development (DSD), the DSD stated CNAs were trained not to move a resident after a fall and to wait for the nurse to assess the situation. The DSD stated it was important CNAs do not move residents after a fall because they do not know whether injuries were present, and moving a resident could worsen potential injuries and cause further harm.During a phone interview on 5/8/2026 at 3:59 p.m. with Registered Nurse Supervisor (RNS) 1, RNS 1 stated when she entered Resident 1's room after the fall, Resident 1 was lying face down on his stomach, and CNA 1 was applying pressure to the resident's forehead. RNS 1 stated staff moved Resident 1 onto his left side so she could assess him. RNS 1 stated the resident had swelling and discoloration around his right eye and an open cut on his forehead. RNS 1 stated Resident 1 appeared calm and did not show signs of pain or discomfort. She stated she authorized moving Resident 1 because he did not appear to be in distress.During a follow^up interview on 5/8/2026 at 4:47 p.m. with CNA 1, CNA 1 stated she moved Resident 1 from lying on his stomach so she could place her hand under his head and apply pressure with a towel to his bleeding forehead. CNA 1 stated after RNS 1 assessed Resident 1, she and three other staff members rolled the resident from side to side to place a sheet underneath him. CNA 1 stated that once the sheet was in place, each staff member held a corner of the sheet and lifted Resident 1 back into the bed. CNA 1 stated RNS 1 told them it was safe to move the resident back to the bed, which was why they proceeded. CNA 1 stated she could not recall whether she had ever received training on moving a resident after a fall.During a review of the facility's policy and procedure (P&P) titled, Falls by a Resident, revised 7/2017, the P&P indicated, When a resident sustains a fall, the licensed nurse is to be notified immediately, and the resident is not to be moved until assessed by the licensed nurse.Cross Reference F684.