STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056416	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayers Memorial Hospital	43563 Hwy 299 E Fall River Mills, CA 96028

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement care planned fall prevention interventions (a set of proactive measures designed to minimize the risk of falls in individuals) for 2 of 4 residents sampled for falls who had been identified as high risk for falls (Resident 1 and 2) when: 1. Resident 1's care planned intervention for staff to follow Resident 1 to his room and assist him with toileting or lying down was not followed. 2. Resident 2's care planned intervention to ensure that Resident 2 was wearing non-skid socks or footwear was not followed. These failures resulted in avoidable falls with broken hips for both Resident 1 and 2 which and rehospitalizations for surgical repairs. This had the potential to negatively impact the residents' physical and emotional well-being and subject them to further falls with injuries. Findings: A review of the facility's policy titled, FALLS-SNF (Skilled Nursing Facility) dated 5/22/23, indicated that a fall is an unplanned descent to the floor which may either be observed or unobserved. The policy indicated the facility is committed to maintaining resident safety by identifying those residents who are at risk for falls, at high risk of injury from falls and implement evidence-based interventions to prevent falls and injury. For residents identified as at risk for falls, the policy indicated that the facility would implement fall prevention measures such as addressing fall risks on the residents' care plan and providing non-skid footwear or shoes. A review of Resident 1's admission Record indicated Resident 1 was admitted on [DATE] with diagnoses that included dementia (memory and decision-making problems), rheumatoid arthritis (arthritis that deforms joints), prostate cancer, vision problems, and high blood pressure. A review of Resident 1's Morse Fall Scale (a fall risk assessment with scores of High Risk-45 or higher, Moderate Risk-25 to 44, and Low Risk- 0 to 25), dated 1/18/24, 3/19/24, 8/24/24, and 10/4/24, was conducted. Resident 1 was at a high risk for falls with a score of 90, due to a history of falls, severe cognitive impairment (ability to remember and make sound decisions), impulsiveness (acts before thinking about the consequences), poor safety awareness, poor vision, and balance problems while sitting and walking. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's post fall Nursing Notes indicated that on: 4/19/24, Resident 1 was found in his room by a Certified Nursing Assistant (CNA), after breakfast on the floor between his recliner and bathroom. 8/10/24, Resident 1 was found on the floor in his room when a CNA heard a thump after lunch. 8/12/24, Resident 1 was found on the floor in his room next to his wheelchair, after supper. 8/24/24, Resident 1 was found on the floor in his room after sliding out of his wheelchair while trying to get into bed at 2 pm. 9/16/24, Resident 1 was found on the floor in his room after attempting to transfer himself from his wheelchair to bed at 4:20 pm. On 10/24/24, Resident 1 was seen by a CNA from the hallway attempting to transfer himself from his wheelchair to his bed and fell on the floor, which resulted in a broken right hip. A review of Resident 1's Nursing Note dated 10/31/24 at 11:10am, written by the Interdisciplinary Team (IDT, a group of facility managers who discuss resident problems and find solutions), indicated that on 10/24/25 at 11:30 am, Resident 1 had a witnessed (observed by another person) fall in his room when he attempted to transfer himself from his wheelchair to his bed. The wheelchair alarm was sounding but the CNA could not reach him in time to prevent the fall. Resident 1 was then transferred to the emergency room (ER) where it was determined he had sustained a right hip fracture that required surgery to be repaired. A review of Resident 1's care plan titled, The Resident is at High Risk for Falls created 9/29/20, included the following interventions: Resident is not to be left alone in room sitting in wheelchair, he enjoys lying in bed. When [Resident 1] is heading toward his room follow him and assist him to the bathroom or to bed. During an interview with the Director of Nursing (DON) on 6/13/25 at 2 pm, the DON confirmed that the facility failed to implement Resident 1's care planned interventions by not following him to his room and assisting him back to bed or to the bathroom, which resulted in an avoidable fall with a right broken hip on 10/4/24. 2. Resident 2 was admitted on [DATE] with diagnoses that included dementia, depression, anxiety, insomnia (difficulty sleeping), repeated falls, chronic pain, heart failure, lung disease, some loss of bowel and bladder control, arthritis, osteoporosis (bone loss), and fractures of the upper spine. A review of Resident 2's Morse Fall Scale, dated 6/23/24, indicated that Resident 2 was at high risk for falls with a score of 90. Resident 2's risk factors included, unsteady on her feet, balance problems, cognitive impairments, and prior falls with injuries and a broken hip. Resident 2 had sustained 11 falls on 4/3/24, 4/8/24, 5/19/24, 8/9/24, 8/27/24, 9/6/24, 9/9/24, 9/20/24, 9/24/24, 10/8/24 which resulted in a broken right hip, and on 1/6/25 which resulted in a broken left hip. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2's At High Risk for Falls care plan, created 6/28/23, included the following interventions: Ensure that the resident is wearing appropriate non-skid footwear when ambulating or mobilizing in a wheelchair. Make sure shoes are comfortable and not slippery. A review of a statement written by CNA 1 on 1/6/25 at 11:15 am, who witnessed Resident 2's fall on 1/6/25 indicated, I had just got done cleaning the resident from a loose bowel movement and she was placed in her wheelchair. While cleaning up the bathroom, the resident made an attempt to get to her recliner, I was not aware she intended to self-transfer to the recliner. During the self-transfer I turned around and saw her slippers slide out from underneath her. She fell from the standing position on her side and landed on her left hip. She hit her left hip first and then her head on the floor. A review of the Interdisciplinary Post Fall committee meeting note dated 1/8/25 at 1:20 pm, indicated the root cause of Resident 2's fall was due to, resident's footwear inappropriate and that Resident 2 was transferred by ambulance to the ER at 11:30 am on 1/6/25, and admitted for surgical repair of a broken left hip. During an interview with Licensed Vocational Nurse (LVN) 1 on 6/17/25 at 1:45 pm, LVN 1 indicated that she was on duty when Resident 2 fell on 1/6/25. LVN 1 confirmed that Resident 2 was wearing slippers that were not non-skid footwear or shoes, and that Resident 2's care plan was not followed. LVN 1 stated she, threw them [the slippers] out after Resident 2 fell.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, record review, facility policy review and video surveillance review, the facility failed to ensure that the pharmacist was responsible for establishing a system of records of receipt and disposition of all controlled medications (medications that have a high potential for abuse and addiction) in sufficient detail to enable an accurate reconciliation, and to ensure that these drugs were handled and administered in a safe and secure manner. This failure allowed narcotic medications to be diverted (stolen or misused) without detection, compromising the facility's ability to ensure the safe and effective use of medications. Residents were placed at potential risk of unrelieved pain, undertreatment, and harm from diverted medications. Findings: A review of the facility's policy titled, Controlled Substance Storage, Receiving, Tracking and Documenting dated 6/25/09, indicated, Receiving and tracking of controlled substances is done in a consistent manner to prevent and detect diversion. An interview with the Director of Nurses (DON) and Director of Safety and Security (DSS) on 6/19/25 at 11:13 am, revealed that the facility identified a narcotic reconciliation issue on 2/14/25 when a Licensed Vocational Nurse (LVN) had requested additional narcotics for Resident 1 when the medication was too soon to be refilled. Video surveillance on 2/4/25 showed the LVN in the locked medication room putting cassetts of narcotics in her jacket. The facility immediately terminated the LVN's employment on 2/18/25 and made the proper agency referrals. The DSS indicated that a detailed narcotic audit was done from August 2024 to February 2025 and reflected that 2550 narcotic tablets and 2 vials of Morphine (a narcotic) liquid were missing. DSS stated, we audited only back to August and determined that there was missing paperwork [yellow control sheets] on 85 narcotic cassettes and 2 vials of liquid morphine. According to the DSS, the facility had identified numerous contributing factors to the theft and loss of narcotic medications to, lack of overflow accountability and pharmacy not tracking yellow control sheets. The DSS stated, the root cause analysis was processes were not followed as we had lots of leadership changes. In an interview with the Pharmacist on 6/19/25 at 12:15 pm, he stated that he was alerted by the DEA (Drug Enforcement Agency, a government agency that enforces the prevention of narcotic diversion and drug trafficking) software system that it was too soon when he tried to refill Resident 1's narcotic pills. He then notified the DON and DSS to begin an investigation. The Pharmacist stated, According to the DEA, once I fill the narcotic and it goes to nursing I am no longer responsible. The Pharmacist confirmed he had no knowledge of his responsibilities according to the Federal regulations and confirmed he had not established and maintained records of receipt and disposition of all controlled medications, performed routine audits to reconcile narcotic drug usage, identify narcotic use discrepancies, or collaborated with facility staff to ensure safe, secure, and appropriate use of narcotic/controlled medications.