STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Loveland Village	2101 S Garfield Ave Loveland, CO 80537

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** 40467 Based on observations, record review and interviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (#1) of three residents out of three sample residents. Resident #1, who was known to be at risk for falls, fell seven times between 12/8/24 and 2/1/25. The resident suffered a hip fracture as a result of one of the falls. The facility could not determine which fall resulted in the hip fracture. Resident #1 had one fall because his bed moved and six falls were because he attempted to self-transfer in or out of bed. Most of his falls were before or after meals and the resident was often incontinent at the time. According to staff, Resident #1 was very routine and would want to go to meals early, return to his room, use the urinal on the edge of his bed and lay down. He would self propel in his wheelchair to and from the dining room. Staff identified difficulty arriving to his room before he self-transferred to and from his bed. Resident #1 had a significant memory deficit and would be frequently reminded to use the call light as an immediate intervention. The facility failed to identify and implement timely interventions for Resident #1 in order to prevent multiple falls of similar occurrence that resulted in a hip fracture, a decrease in ability and a decision to place the resident on hospice services. Additionally, observations and record review during the survey revealed facility staff failed to consistently implement care planned fall interventions when Resident #1 was in bed (see observations below). Findings include: I. Facility policy and procedure The Fall Prevention and Management policy, revised 7/29/24, was provided by the nursing home administrator (NHA) on 2/27/25 via email. The policy's purpose read in pertinent part, To promote resident well-being by developing and implementing a fall prevention and management program; to identify risk factors and implement interventions before a fall occurs; to give prompt treatment after a fall occurs; and, to provide guidance for documentation. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The policy identified the facility should review and update the care plan with any changes/new interventions and continue to monitor the condition and the effectiveness of the interventions. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included other sequelae of cerebral infarction (long term complications that can occur following a stroke), unspecified dementia without behavioral disturbance, cognitive communication deficit, fracture of unspecified part of the neck of right femur, subsequent encounter for a closed fracture with routine healing, difficulty walking, unsteadiness on feet, muscle weakness, lack in coordination, need for assistance with personal care and urgency of urination. According to the February 2025 CPO, the resident had repeated falls. The 1/31/25 minimum data set (MDS) assessment documented Resident #1 had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. According to the MDS assessment, there was not evidence of an acute change in mental status from the resident's baseline. The resident was dependent on staff for most of his activities of daily living (ADL), including transferring from surface to surface. He used a wheelchair for mobility. The MDS assessment indicated Resident #1 did not have rejections of care, physical or verbal behaviors directed to others or other behaviors or other behavioral symptoms not directed at others. The MDS assessment identified Resident #1 had a history of falls in the past six months and one fall without injury since his last assessment. Resident #1 had a life expectancy of six months or less. B. Resident observation and interview On 2/25/25 at 12:46 p.m. Resident #1 was lying in his bed. The bed was flush against the wall, his bed wheels were locked and his call light was within reach. -Resident #1 did not have his bed in the low position, as identified as a fall intervention in the resident's care plan (see care plan below) or a pool noodle under the fitted sheet between his body as recommended by the occupational therapist (OT) (see progress notes below). Resident #1 said he did know the details of his falls or why he fell . He said he only knew that he had a fall. He said he was not currently in pain. On 2/26/25 at 1:04 p.m. Resident #1 was lying in bed. His bed was in a low position and a pool noodle was between his body and the wall. -However, the pool noodle was on top of the blanket and sheets and not under the fitted sheet, as identified in the occupational therapy recommendation (see OT notes below). C. Visitor interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A visitor for Resident #1 was interviewed on 2/26/25 at 1:06 p.m. The visitor said he had visited with the resident everyday for the past couple of years. He said the pool noodle was placed on the bed so Resident #1 would not fall between the bed and the wall. D. Record review 1. Care plan Resident #1's fall care plans for an actual fall, initiated 5/3/23 and revised 2/18/25, and the resident's at risk for falls care plan, initiated 3/7/24, indicated the resident was at risk for falls related to deconditioning, cognitive deficits, confusion, gait imbalance and decreased safety awareness. The resident had a history of falls, poor communication/comprehension and was unaware of his safety needs. The fall care plan for actual falls indicated other fall factors included cerebral infarction, fracture of the left femur, fall history and anger issues. According to the actual fall care plan, Resident #1 sustained the following falls: a fall on 5/2/23 without injury; a fall on 5/6/23 without injury; a fall on 5/11/23 without injury; a fall on 4/13/24 without injury; a fall on 4/27/24 with a minor injury; a fall on 8/8/24 without injury; a fall on 12/8/24 with a head injury requiring stitches; a fall on 12/9/24 without injury; a fall on 12/13/24 without injury; a fall on 12/19/24 without injury; a fall on 12/30/24 without injury; a fall on 1/2/25 without injury; a fall on 1/24/25 with laceration to the forehead and complaints of hip pain, and the resident was sent to the hospital; and, a fall on 2/1/25 with a minor injury of a skin tear to his left elbow. The following interventions were added to the resident's care plan on 3/7/24, after the facility determined Resident #1 was at risk for falls: Remind the resident not to bend over to pick up dropped items, encourage him to use a grabber/reaching device or to ask for assistance, ensure the resident was wearing appropriate footwear of fully enclosed slip resistant shoes or gripper socks when ambulating or mobilizing in wheelchair, monitor the resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function, monitor visual and auditory impairments, ensure correct bed height by having bed in lowest position when resident was in room alone and reviewing as indicated for significant changes in cognition, safety awareness and decision-making capacity. The fall intervention initiated on 5/1/23 and revised on 5/1/23 documented the staff was to remove the resident's foot pedals from the wheelchair when staff was not pushing him. The fall interventions initiated on 5/3/23 and revised on 5/9/23 documented the staff should review Resident #1's history of recent or recurrent falls, ensure correct bed height by keeping in low position. According to the intervention, most of the resident's falls occurred at the bottom of the bed related to himself ambulating to the bathroom. The intervention indicated the resident had urinals available. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Another fall intervention initiated on 5/3/23 and revised on 5/9/23 documented staff should ensure the resident was wearing appropriate footwear. According to the care plan, the resident would refuse gripper socks and non-slip shoes and liked being barefoot. According to the care plan intervention, the resident's fall on 5/6/23 identified the resident had gripper socks on but the gripper side was on top of his foot. The staff was educated and directed to monitor for proper placement of the socks with grips on the bottom of foot. The fall intervention initiated on 5/3/23 and revised on 4/16/24 documented that on 4/15/24, staff added Dycem (non-slip material) to the resident's recliner to help prevent the resident from sliding and falling. The fall intervention initiated on 12/11/24 and revised on 2/6/25 documented staff requested a physical therapy (PT) consult for strength and mobility and OT on 12/13/24 for transfers, PT, OT and activities to assess weakness, room safety, falls and boredom on 1/8/25 and on 2/1/25, the resident's bed was placed in low position and OT was to assess for noa (positioning) bars and bed positioning. The fall intervention initiated on 5/6/23 and revised on 1/31/25 directed staff to educate the resident not to bend over to pick up dropped items and encourage the resident to use a grabber or to ask for assistance. The care plan intervention documented the resident refused to allow staff to standby for assistance to the toilet. The 5/6/23 intervention directed staff to make sure the resident's call light was always visible and continue to encourage him to use it. According to the intervention, staff was educated on 12/19/24 to frequently monitor the resident, offer to transfer from bed to wheelchair before and after meals as well as in the morning and at night to prevent falls. The fall intervention initiated on 5/6/23 and revised on 1/31/25, documented that on 2/1/25 the resident needed his environment to be modified for maximum safety. The fall intervention initiated on 2/1/25 and revised on 2/3/25 directed staff to ensure Resident #1's bed was locked and against the wall in a low position. The fall intervention initiated on 5/3/23 and revised on 2/6/25 directed staff to review the resident as indicated for significant changes in cognition, safety awareness and decision-making capacity. According to the intervention, staff obtained laboratory work (labs) to rule out infections on 2/1/25. The fall intervention initiated on 5/3/23 and revised on 2/18/25 directed staff to provide activities that promoted exercise and strength building where possible, round before and after meals to stand/assist with transfers on 12/8/24 and add an art volunteer for social interaction. According to the care plan intervention, on 12/30/24 the resident's friend returned from vacation and the resident was no longer attempting to self-transfer. The friend would speak to the resident about safety and remind him to use the call light. The care plan intervention directed staff to encourage activities and offer one-to-one activities in the resident's room to fill the void while the friend was out of town to help prevent falls. -However, Resident #1 self-transferred on 1/2/25 and fell again. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The end of life care plan, initiated on 1/30/25, documented Resident #1 had a terminal prognosis related to non-operative management of a right femoral fracture. Hospice services were put into place. The care plan directed staff to adjust the provision of ADLs to compensate for the resident's changing abilities and encourage participation to the extent the resident wished to participate. Resident #1's activities of daily living (ADL) care plan, identified the resident had an ADL performance deficit. The ADL transfer between surfaces intervention, revised 1/28/25, directed staff to use a two-person total lift transfer. 2. Pattern of falls Review of Resident #1's electronic medical record (EMR) from 12/1/24 through 2/25/25 revealed Resident #1 sustained seven falls during that time frame, including falls with injury. The falls were as follows: a. Fall with injury on 12/8/24 The 12/8/24 incident note documented someone was heard yelling for help down the hall. The certified nurse aide (CNA) reported Resident #1 was found on the floor. The resident was sitting on his bottom on the floor with his back to the dresser. The resident's wheelchair laid in a folded position on the floor at his feet. The resident had gripper socks on and his pants were slightly pulled down. According to the note, the resident had significant bleeding from a scalp wound. The note identified the wound as a quarter-sized skin tear with a two inch indentation to his scalp that continued to bleed when paramedics arrived. The incident note documented there was dried blood on the floor and it was undetermined how long the resident was on the floor. The registered nurse (RN) assessed for other injuries and no other injuries were identified. The 12/8/24 hospital emergency department notes identified Resident #1 had a laceration on his forehead requiring sutures and a hematoma (a localized collection of blood under the skin and outside the blood vessels). The 12/8/24 fall scene huddle worksheet was provided by the director of nursing (DON) on 2/25/25 at 10:20 a.m. The fall huddle worksheet documented Resident #1 was found on the floor incontinent of urine at 8:45 a.m., 45 minutes from when he last had contact with staff. The worksheet identified the resident was sitting in front of his dresser with his wheelchair on one side of him and blood on the floor on the other side of him. The 12/8/24 incident report was provided by the DON on 2/25/25 at 9:35 a.m. The incident report identified the fall occurred at 9:35 a.m. According to the incident report, predisposing physiological factors of the fall included impaired memory, confusion and incontinence. -The incident report documented the fall occurred at a different time than was identified on the fall huddle worksheet. The 12/8/24 hospital emergency department notes documented Resident #1 fell on [DATE] and was sent to the hospital. He had a laceration on his forehead requiring sutures and a hematoma. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A 12/8/24 progress note identified the resident returned back to the facility from the emergency roiagnom on [DATE] with stitches applied to the artery that he opened during the fall. b. Fall on 12/9/24 The 12/9/24 fall tool identified Resident #1 was at high risk for falls. The 12/9/24 incident note identified Resident #1 had a total lift assist from the floor and was placed in his wheelchair. The note documented the resident denied hitting his head and would not allow a skin assessment because he was agitated and impatient. He had no pain with range of motion but he had slight pain with palpation to the right hip. According to the note, the resident fell on his right side the day before (12/8/24). The resident was assessed by the nurse practitioner (NP). The incident note identified the immediate intervention was education to the resident on the importance of using the call light for assistance before trying to get himself out of bed. The 12/9/24 fall huddle worksheet documented Resident #1 fell when he was attempting to self-transfer. He was last seen 20 minutes prior to the CNA finding him on the floor. The drawing on the fall huddle worksheet indicated the resident was found on the floor next to his bed. The resident was incontinent of urine and bowel. According to the fall huddle worksheet, the root cause of the fall was the resident's cognition and not using his call light. The 12/9/24 fall incident report identified the fall happened at 11:00 a.m. The report indicated the resident did not have injuries observed at the time of the incident. According to the report, the factors of the fall were weakness, gait imbalance, impaired memory, incontinence and not using his call light. The incident report identified the resident said he was trying to get out of bed to go to lunch. The 12/9/24 NP note identified the resident was seen for follow-up after multiple falls with a temporal artery laceration requiring sutures. The NP note documented Resident #1 was seen on 12/9/24, self-propelling his wheelchair to the dining room. The note indicated he was alert and oriented per his baseline and was calm and pleasant. He denied chest pain, palpitations or shortness of breath. The resident denied headache or dizziness. The note documented he had a recent fall (12/8/24) where he struck his head and sustained a laceration to the temporal artery which required an emergency department evaluation and multiple sutures. A CT (computed tomography) scan was conducted and he was negative for further acute process or brain bleed. Resident #1 denied pain and appeared comfortable on the exam since returning from the hospital. The resident had had another unwitnessed fall on 12/9/24 without injury. According to the note, Resident #1 had a memory impairment with dementia. The note identified he was impulsive and needed to be monitored for acute changes in his cognition and behaviors. The 12/10/24 communication visit with the physician note documented PT orders were requested for weakness, transfers and falls. According to the note, Resident #1 had changes of weakness as well as refusal of oral care and dental care. The resident had severe halitosis that could indicate an infection, a request for evaluation and orders were made. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 12/11/24 falls/interdisciplinary team (IDT) note documented the IDT met on 12/11/24 to review the 12/9/24 fall. Resident #1's medications, mobility status, room arrangement and interests and preferences were reviewed. According to the note, the intervention was for PT to evaluate and treat and staff would continue to monitor through the next evaluation date. The 12/31/24 PT note documented Resident #1 would benefit from continued assistance with all transfers due to his cognitive impairment. According to the note, he responded well to gentle guidance on proper set up. c. Fall on 12/13/24 The 12/12/24 at 3:52 a.m. (the day prior to the 12/13/24) fall) health status note revealed an increase in Resident #1's behaviors after the resident had a recent two falls. The note documented Resident #1 was very agitated on the 12/12/24 overnight shift and tried to get out of bed several times, yelling for help instead of using his call light and was able to communicate incontinence. Resident #1 told the staff that he had not slept in three days. The note identified lab work and a urine analysis would be obtained on the morning of 12/13/24 due to the resident's increase in behaviors. -The note did not identify if the resident was asked if he was in pain. The 12/13/24 incident note identified the resident had another unwitnessed fall. According to the note, the resident was found on the floor by a CNA. The resident was assessed and no injuries were identified. The note documented Resident #1 said he was trying to get into bed when he fell . The 12/13/24 fall huddle worksheet documented Resident #1 was found in his room on the floor next to his bed at 8:30 a.m. The resident was attempting to self-transfer when he fell . According to the worksheet, he was last seen at 7:00 a.m., one hour and 30 minutes prior to the fall. The worksheet identified the resident was wearing regular socks and not the gripper non-skid socks. The resident was incontinent of urine when he was found. The worksheet did not identify when the resident was last toileted. According to the fall huddle worksheet, the root cause of the fall was he was self-transferring. The 12/13/24 fall incident report documented Resident #1 was trying to get into bed. According to the report, there were no injuries observed at the time of the incident, the resident's range of motion was at baseline and he had weakness and a noted decline over the past few weeks. The fall incident report identified confusion as a factor to the fall. The 12/13/24 communication to the physician note identified the resident's lab results did not identify an infection. According to the note, the decline appeared to be a disease progression. The 12/16/24 physical therapy (PT) evaluation and plan of treatment was provided by the NHA on 2/26/25 at approximately 4:30 p.m. The PT goal was to improve ease of transfers to decrease Resident #1's risk for falls. According to the evaluation, the resident's 12/16/24 baseline for transfers was partial to moderate staff assistance needed for bed mobility, toilet transfers, sit-to-stand and chair-to-bed-to-chair transfers. The PT evaluation identified the resident had decreased functional capacity, decreased safety awareness, pain, strength impairments and procedural memory limitations. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 12/16/24 PT treatment encounter note revealed Resident #1 required total setup of his wheelchair in front of his bed with moderate assistance for a stand-pivot transfer and moderate assistance of bilateral leg management to move from a sitting position to laying down. The 12/18/24 care plan change note documented the IDT met and reviewed his fall on 12/13/24. According to the note, the intervention was for staff to round before and after meals to assist with transfers. The note indicated OT continued to work with him and a volunteer was requested to visit with him. d. Fall on 12/19/24 The 12/19/24 incident note identified Resident #1 had another unwitnessed fall in his room. The note documented Resident #1 fell on [DATE] at 7:15 p.m. He was observed sitting on the floor with bilateral hands grabbing the transfer bar on his bed to sit upright. His range of motion was at his baseline with all of his extremities but he had a slight redness on his left lateral back near his spine. According to the incident note, the resident was incontinent of bowel and bladder when he was found. The resident was assisted from the floor to his bed by use of a mechanical lift. The staff provided incontinent care and his bed was placed in a low position and his call light was placed within reach. The resident was reminded to use the call light for staff assistance. -Review of the progress notes did not identify Resident #1's 12/19/24 fall was reviewed by the IDT. -The 12/19/24 fall huddle worksheet did not identify when the resident was last seen by staff or when he was last toileted. The fall huddle worksheet did not identify the root cause of the fall. The 12/19/24 fall incident report documented Resident #1 was found sideways on the floor, parallel to the bed, facing towards the head of the bed and sitting on his bilateral buttock and his feet extending away from the bed and his bilateral hands gripping the transfer bar to keep himself upright. According to the incident report, Resident #1 said he didn't do anything. According to the incident report, factors of the fall included confusion, impaired memory and incontinence. The 12/19/24 physician note documented Resident #1's orientation level was stable but globally worsening over time. The note indicated the resident refused care intermittently and was agitated but was never aggressive. According to the note, the resident had functional impairments, bowel or bladder complications, new or worsening wounds, and significant cognitive deficits with high risk for falls with injury that required frequent monitoring. e. Fall on 12/30/24 The 12/30/24 incident note identified Resident #1 had another unwitnessed fall in his room while self-transferring. The note documented the resident was found on the floor by his family member. According to the note, the nurse had given the resident his medication on 12/30/24 at 12:06 p.m. The nurse then told the resident to wait for someone to help him go to bed and not transfer himself to bed. The note read the resident said he would wait. The note documented there were nine minutes between the time the resident was told to wait for help and when the resident's family member found him on the floor. The resident refused the skin assessment after the fall. Range of motion was conducted and the resident denied pain. The note indicated there were no new obvious injuries observed and the resident was assisted to bed per his request. (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	The 1/8/25 care plan change progress note documented the IDT met on 1/8/25 and reviewed Resident #1's 1/2/25 fall. The note identified Resident #1 was probably going to be discharged from PT because he did not want to participate. The note identified the facility attempted to have Resident #1 visit with a volunteer but he was not receptive to the volunteer. The note indicated the resident's friend was going to begin visiting again. -The care plan change note did not identify what new interventions the facility was going to put into place to prevent repeated falls of a similar nature. g. Incident of unknown source on 1/24/25 with major injury The 1/24/25 incident note identified that on 1/24/25 Resident #1 complained of pain to his right leg. The nursing assessment identified his right foot was pointing laterally outward. The resident denied pain but was moaning in pain. His leg was not able to go back to a neutral position, identifying a possible issue. The note documented the fall on 12/8/24 identified the resident was found on his right side and was sent to the hospital to repair a skin tear. The resident did not express right leg or hip pain as a result of the 12/8/24 fall. The note identified out of 33 pain ratings between 12/8/24 and 1/24/25, five of the pain ratings were identified at a pain level of 3 out 10,two of the pain ratings were identified at a pain level of 2 out 10, two of the pain ratings were identified at a pain level of 1 out 10 and 24 of the pain ratings were identified at pain level of zero out 10. The incident note indicated the resident often denied pain. The incident note documented Resident #1 continued to get out of bed and into his wheelchair. According to the note, the facility was unsure if that was the cause of the fracture or if any of the other falls were a result of the injury. Resident #1 denied any new fall or injury on 1/24/25 other than some pain in his hip and needed to be encouraged to go to the hospital for an assessment. Review of Resident #1's level of pain log between 12/8/24 and 1/24/25 revealed the resident's pain rating was logged everyday at least once a day, except between 1/11/25 and 1/22/25. The pain log on 1/23/25 identified the resident complained of pain at a rating of 7 out 10 at 1:52 p.m. He had a pain level of 3 out 10 on 1/23/25 at 5:06 p.m. Resident #1's pain level was 7 out of 10 on 1/24/25 at 11:25 a.m. and again at 2:07 p.m. The 1/24/25 nurse practitioner note revealed Resident #1 told the NP on 1/24/25 that his pain was primarily in his right leg and had been increasing over the last week. The NP note indicated an x-ray, conducted on 1/24/25, identified an acute femoral neck fracture and the resident would be sent to the emergency room (ER) for further evaluation. The 1/24/25 injury of unknown source incident report documented Resident #1 had a very close friend who visited often and the resident was very calm and happy during these visits. He would listen to the advice of his friend and the friend could also often get the resident to be compliant. The friend went on a long vacation and the resident was upset and lonely. The facility attempted different people to try to visit with the resident, including the resident's family. The report indicated the resident had several falls while the friend was absent from the facility. The incident report identified the falls on 12/8/24, 12/9/24, 12/13/24, 12/19/24, 12/30/24 and 1/2/25. The incident report identified one of the falls resulted in a laceration to Resident #1's forehead and he was sent to the hospital to evaluate his head injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065139	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society -- Loveland Village	2101 S Garfield Ave Loveland, CO 80537

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The review of the falls identified the resident would continue to self-transfer in and out of bed and was frequently incontinent when the falls occurred. The falls would often occur after meals (see interviews below). The 1/26/25 admission/readmission note revealed Resident #1 returned to the facility on [DATE] from the hospital with a right femoral neck fracture. The resident and his family had chosen not to do surgical intervention of the fracture. According to the note, the resident was returning to the facility on hospice services. The 1/29/25 care conference note identified members of the IDT, hospice and the resident's family attended the conference. The members of hospice explained their role and how often they would be visiting Resident #1. The care conference note indicated the resident had a fall that resulted in a broken hip which could not be repaired so he returned to the facility on hospice services. The note documented Resident #1 had his own routine and was able to self propel his wheelchair. The 1/31/25 OT evaluation and treatment plan, beginning on 1/31/25, indicated OT was to help the resident with pain management with positioning in b[TRUNCATED]