STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065153	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown origin and misappropriation of resident property for one (#1) of two residents out of three sample residents. Specifically, the facility failed to timely report an injury of unknown origin for Resident #1 to the State Agency. Findings include: A. Facility policy and procedure The Accidents and Incidents-Investigating and Reporting policy, revised July 2017, was provided by the nursing home administrator (NHA) on 3/6/25 at 6:02 p.m. The policy read in pertinent part, All accidents or incidents involving residents, employees, visitors, vendors, occurring on premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and or the department director or supervisor shall complete a report of incident /accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The Unusual Occurrence Reporting policy, revised December 2007, was provided by the NHA on 3/6/25 at 6:02 p.m. The policy read in pertinent part, As required by the federal or state regulations, our facility reports unusual currencies or other reportable events which affect the health, safety, or welfare of residents, employees or visitors. According to the policy, unusual occurrences would be reported to the appropriate agencies as required by current law and or regulations within 24 hours of such incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event would be sent or delivered to the State Agency within 48 hours of reporting the event as required. The policy identified allegations of abuse, neglect and misappropriation of resident property and any other occurrences that interfered with facility operations and had effects on the welfare, safety, or health of residents, employees and visitors would be reported to the appropriate agency. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 12/29/24. According to the December 2024 computerized physician orders (CPO), diagnoses included unspecified osteoarthritis, edema, pain in the and left knee, history of falling, type 2 diabetes without complications, muscle weakness, acute embolism and thrombosis of unspecified deep vein of left lower extremity, unspecified dementia on specificity with psychotic disturbance, anxiety disorder and chronic pain syndrome. The 12/16/24 minimum data set (MDS) assessment documented Resident #1 had severe cognitive impairments per staff assessment for mental status and presented with long term and short term memory loss. The resident required partial to moderate assistance with most of her activities of daily living (ADL). She used a walker for mobility. According to the MDS assessment, Resident #1 had hallucinations and delusions. 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 did not identify the resident had a fall at the facility since her admission to the facility. C. Facility reported incident The State Agency reporting portal identified an allegation of neglect was reported for Resident #1 on 1/23/25, regarding an incident that occurred on 12/29/24. -The facility reported the incident to the State Agency 24 days after the reporting requirements. D. Record review Review of Resident #1's electronic medical record (EMR) revealed Resident #1's last known fall at the facility was on 2/8/24. The 12/26/24 skin assessments did not identify any skin concerns or injuries. The 12/29/24 health status note documented by licensed practical nurse (LPN) #1, identified a CNA attempted to move Resident #1 and she started to complain of severe pain. The CNA reported the pain to LPN #1. The resident cried out in pain when her hips were moved slightly. Resident #1 was diaphoretic, her oxygen saturation levels were at 55% and her blood sugar was at 340 milligrams/deciliter (mg/dl). According to the note, the resident's oxygen was set at 2 lpm (liters per minute) with a face mask. Her oxygen was increased to 3 lpm and her saturation levels rose to 77%. Resident #1 was full code and 911 was called. The note identified the resident in pain and cried out when paramedics transferred her from the bed to a gurney. The note identified Resident #1 was her own responsible party and she was aware she was going to the hospital. The note indicated the medical director (MD) was notified. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The pain log identified Resident #1 last pain level check was on 12/29/24 at 12:10 a.m. The resident's documented pain level was at zero out of 10. The facility investigation summary was provided by the NHA on 3/4/25 at approximately 4:30 p.m. The summary identified the facility was notified that Resident #1 had right and left hip fractures. The hospital contacted registered nurse (RN) #1 on 12/29/24 and notified the RN of a bruise/hematoma on her left proximal thigh. The summary indicated the facility staff was asked about the bruise and none of the staff saw a bruise. -However, the facility failed to report the fractures, which were of unknown origin, until 1/23/25. The 12/29/24 hospital #1 emergency department physician note documented Resident #1 was in significant pain and a computed tomography (CT) scan identified bilateral fractures and an ortho-surgeon was contacted. The resident had a large left-sided proximal thigh hematoma with a suspicion of compartment syndrome. According to the note, Resident #1 was transferred to hospital #2 for higher level care. The 12/29/24 hospital #1 radiology report documented Resident #1 had intra-articular subcapital impacted right hip fracture, probably subacute and a subacute intertrochanteric left hip fracture, pathological fracture based on the CT scan. The resident had osteoarthritis, osteopenia and degenerative changes in the lower spine with multiple wedge deformities The 12/29/24 hospital #2 emergency department (ED) records documented Resident #1 was transported to hospital #2 for multiple concerns including bilateral femur fractures. She was admitted to hospital #2 for possible surgical repair of her fractures. The ED notes identified Resident #1 was not able to move her hips due to the broken femurs. She had a left hip hematoma that was determined not to be compartment syndrome. She had T-spine fractures and sepsis related to a urinary tract infection (UTI). According to the notes the resident would have a right hemiarthroplasty (a half joint hip replacement procedure). The resident had a fracture of her left femur, right femur and a fracture of multiple thoracic vertebrae E. Education The 1/28/25 staff education participation record on reporting was provided by the NHA on 3/6/24 at 6:02 p.m. According to the 1/28/25 education record, 71 staff were informed/reminded to report changes, loss of balance (without a fall), falls slips, trips, physical contact, choking, behaviors or any change of condition in a resident to the nurse. The education record documented it was the nurse's responsibility to document and assess once it was reported to the nurse. F. Staff interviews The NHA was interviewed on 3/5/25 at 4:05 p.m. She said after the 12/29/24 incident with Resident #1, she started an investigation by reviewing the hallway video and interviewing staff. She said she did not save the interview notes and the video only saved for two weeks. She said she reported the injury of unknown origin late on 1/23/25 because she did not know it was reportable. Cross-reference F610, failure to thoroughly investigate an injury of unknown origin. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said on 12/30/24 an ED nurse contacted the facility and asked about a bruise on Resident #1's left outer hip. The NHA said the staff did not see the bruise when she was assessed by the RN. She said she did not believe the bruise was caused at the facility. She said the bruise could have occurred at the hospital or when the paramedics put her on a gurney. The NHA said she did not believe Resident #1 could have fallen at the facility to break her hip because she would not have been able to pick herself off the floor with a broken hip and put herself back to bed. The director of nursing (DON) was interviewed on 3/5/25 at 5:45 p.m. The DON said LPN #1 notified her to inform her that Resident #1 was sent to the hospital because she was screaming in pain. The DON said the resident was diagnosed with fractures to both of her hips. The DON said she did not know how the fractures occurred when it was reported to her. LPN #1 was interviewed on 3/6/25 at 10:53 a.m. LPN #1 said Resident #1 was fine on the evening of 12/28/24. She said the resident had no reports of pain and she walked normally down to her room. She said the CNAs checked on her every two hours. She said when the staff went to get her up to get dressed, she started crying in pain. LPN #1 said she tried to get her up to see if she could bear weight but she could not stand. She said she assessed Resident #1 with range of motion and hip palpitations (touch). She said she was able to look at the resident's skin a little bit but did not see any concerns. LPN #1 was interviewed on 3/6/25 again at 11:06 a.m. She said she did not see a bruise on the resident's hip or leg but just remembered she saw a small lump on Resident #1's forehead about nickel-sized with some coloring to the skin. She said she did not think the lump was new because new bruising was usually bright purple. She said she did not document or report the lump on her forehead. The DON was interviewed on 3/6/25 at 4:14 p.m. The DON said unexplained injuries, such as what happened to Resident #1, should have been reported within 24 hours and it was not reported timely.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to thoroughly investigate an allegation of abuse and neglect for one (#1) of one resident out of three sample residents. Specifically, the facility failed to complete a thorough investigation when Resident #1 sustained an injury of unknown origin. Findings include: I. Facility policy and procedure The Accidents and Incidents-Investigating and Reporting policy, revised July 2017, was provided by the nursing home administrator (NHA) on 3/6/25 at 6:02 p.m. The policy read in pertinent part, All accidents or incidents involving residents, employees, visitors, and vendors occurring on premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and or the department director or supervisor shall promptly initiate a document investigation of the accident or incident. The policy identified the following data should be reported on a report of incident/accident form: The date and the time the accident or incident took place; the nature of the injury/illness; the circumstances surrounding the accident or incident; where the accident or incident took place; the names of witnesses and their accounts of the accident or incident; the injured person's account of the accident or incident; the time the injured persons attending physician was notified, as well as the time of the physician's response and his or her instructions; the date and time the injured person's family was notified and by whom; the condition of the injured person including his or her vital signs; the disposition of the injured; any corrective actions taken; follow up information; other pertinent data is necessary or required; and the signature and title the person completing the report. The policy identified the following steps that should be taken after the initial data was collected: The nurse supervisor/charge nurse and or the department director or supervisor shall complete a report of incident /accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The director of nursing (DON) shall ensure that the administrator receives a copy of the incident/accident form on each occurrence. The incident/accident reports will be reviewed by the safety committee for trends related to the accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. II. Resident #1 (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #1, age greater than 65, was admitted on [DATE] and discharged to the hospital on 12/29/24. According to the December 2024 computerized physician orders (CPO), diagnoses included unspecified osteoarthritis, edema, pain in the left knee, history of falling, type 2 diabetes without complications, muscle weakness, acute embolism and thrombosis of unspecified deep vein of left lower extremity, unspecified dementia on specificity with psychotic disturbance, anxiety disorder and chronic pain syndrome. The 12/16/24 minimum data set (MDS) assessment documented Resident #1 had severe cognitive impairments, per staff assessment, for mental status and presented with long term and short term memory loss. The resident required partial to moderate assistance with most of her activities of daily living (ADL). She used a walker 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 did not identify the resident had a fall at the facility since her admission to the facility. B. Facility investigation An investigation packet for Resident #1 was provided by the NHA on 3/4/25 at approximately 4:30 p.m. The packet included a summary of the events that occurred on 12/29/24, a police report, an emergency department physician report from hospital #1, a radiology report from hospital #1 and progress notes from the facility. The 12/29/24 summary of events documented on the night of 12/28/24, Resident #1 was sitting in the recliner in the common area, she was then toileted in the shower room by certified nursing assistant (CNA) #1 and CNA #2. The resident was then assisted to her room and to bed. The resident was sleeping and her brief was dry until 12/29/24 at 4:30 a.m. According to the summary, Resident #1 was incontinent of bowel, which was unusual for her, and she was soaking wet with sweat. The CNAs began to turn her on her side and she started to scream and scratch at them. The resident was diaphoretic (sweating) and licensed practical nurse (LPN) #1 was notified. LPN #1 assessed the resident and she hollered out when her hips were palpated (touched). The resident was hypoxic (low oxygen). The staff finished cleaning her up and the paramedics were called to transport the resident to the hospital. The summary identified the facility was notified that Resident #1 had right and left hip fractures. The hospital contacted registered nurse (RN) #1 on 12/29/24 and notified the RN of a bruise/hematoma on her left proximal thigh. The summary indicated the facility staff was asked about the bruise and none of the staff saw a bruise. The skin assessments on 12/5/24, 12/12/24, 12/19/24 and 12/26/24 did not identify a bruise. The 12/29/24 hospital #1 emergency department physician note documented Resident #1 was in significant pain and a computed tomography (CT) scan identified bilateral hip fractures and an orthopedic-surgeon was contacted. The resident had a large left-sided proximal thigh hematoma with a suspicion of compartment syndrome (build up of pressure in the body). According to the note, Resident #1 would be transferred to hospital #2 for higher level care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/29/24 hospital #1 radiology report documented Resident #1 had an intra-articular subcapital impacted right hip fracture, probably subacute and a subacute intertrochanteric left hip fracture, pathological fracture based on the CT scan. The resident had osteoarthritis, osteopenia and degenerative changes in the lower spine with multiple wedge deformities. A 1/25/25 police report documented hospital #1 identified Resident #1 had hip and spinal fractures. The resident had both old and new fractures. According to the report, the medical team at hospital #2 was suspicious that Resident #1 went to bed and woke up with hip fractures without a fall. The report identified the resident's hospice nurse reported Resident #1 passed away on 1/23/25. The report documented the hospice nurse felt the injuries were suspicious because no one knew what happened to cause the injuries. A 1/30/25 police report documented the coroners office was contacted on 1/28/25 and Resident #1's death was ruled an accident. According to the police report, the coroner felt there were no signs of a fall. The fractures to her bones were from use and not injury. -The review of the provided facility investigation did not include staff or resident interviews after the 12/29/24 incident. C. Record review Review of Resident #1's electronic medical record (EMR) revealed Resident #1's last known fall at the facility was on 2/8/24. The 12/29/24 health status note documented by licensed practical nurse (LPN) #1, identified a CNA attempted to move Resident #1 and she started to complain of severe pain. The CNA reported the pain to LPN #1. The resident cried out in pain when her hips were moved slightly. Resident #1 was diaphoretic, her oxygen saturation levels were at 55% and her blood sugar was at 340 milligrams/deciliter (mg/dl). According to the note, the resident's oxygen was set at 2 lpm (liters per minute) and was applied with a face mask. Her oxygen was increased to 3 lpm and her saturation levels rose to 77%. Resident #1 was a full code and 911 was called. The note identified the resident was in pain and cried out when paramedics transferred her from the bed to the gurney. The note identified Resident #1 was her own responsible party and she was aware she was going to the hospital. The note indicated the medical director (MD) was notified. The pain log identified Resident #1 last pain level check was on 12/29/24 at 12:10 a.m. The resident's documented pain level was at zero out of 10. The 12/29/24 hospital #2 emergency department (ED) notes documented Resident #1 was transported to hospital #2 for multiple concerns, including bilateral femur fractures. She was admitted to hospital #2 for possible surgical repair of her (femur) fractures. The ED notes identified Resident #1 was not able to move her hips due to the broken femurs. She had a left hip hematoma that was determined not to be compartment syndrome. She had T-spine (thoracic spine) fractures and sepsis (infection of the blood) related to a urinary tract infection (UTI). According to the notes, the resident would have a right hemiarthroplasty (a half joint hip replacement procedure). The resident had a fracture of her left and right femur and multiple thoracic vertebrae fractures. According to the ED notes, the fractures were chronic, identifying the bone fractures were not healed properly. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Staff interviews The NHA was interviewed on 3/5/25 at 4:05 p.m. The NHA said after the 12/29/24 incident with Resident #1, she started an investigation by reviewing the hallway video and interviewing staff. She said she did not save the interview notes and the video only saved for two weeks. The NHA said on 12/30/24, the video surveillance revealed the resident was assisted back to her room by CNA #1 and CNA #2 between 6:15 p.m. and 6:30 p.m. Resident #1 did not have visitors or other residents enter her room after she went to bed. She said the resident reported pain while laying in bed when the staff tried to change her on the overnight shift. LPN #1 assessed the resident and sent her to the ED related to pain with movement and low oxygen saturation levels. The NHA said an ED nurse contacted the facility and asked about a bruise on the resident's left outer hip. The NHA said the staff did not see the bruise when she was assessed by LPN #1. She said she did not believe the bruise was caused at the facility. She said the bruise could have occurred at the hospital or when the paramedics put her on a gurney. The NHA said she did not believe Resident #1 fell at the facility to break her hip because she would not have been able to get off of the floor with a broken hip and put herself back to bed. The director of nursing (DON) was interviewed on 3/5/25 at 5:45 p.m. The DON said LPN #1 notified her to inform her that Resident #1 was sent to the hospital because she was screaming in pain. The resident was diagnosed with fractures to both of her hips. The DON said CNA #1 and CNA #2 were her CNAs at the time of the incident. CNA #2 was shadowing CNA #1 at the time because she only worked periodically and needed to learn the residents on the hall. The DON said she was told by the staff that Resident #1 had no indications of pain or concerns the day before the incident. She said the resident mostly sat in the lounge in the living room all day and told jokes. The DON said she interviewed all the day shift staff. She said she did not remember when Resident #1 was last toileted or if she had asked staff when the resident was last toileted. She said she hand wrote all her notes and had given them to the NHA. She said in the report, it was noted the resident was toileted every two hours, so she would have been checked on every two hours. Resident #1 was dry the last time they checked on her before the incident. The DON said Resident #1 would usually take her own brief off and throw it on the floor if it was wet. She said the next time she was checked on, she had a bowel movement. The DON said staff tried to change the resident but that was when she started to scream in severe pain. She said the resident's vital signs were taken and Resident #1's blood sugar level was 340 mg/dl, which was high for her. She said her oxygen saturation levels were at 55%, which could be life threatening. Resident #1 did not normally need to wear oxygen. She said LPN #1 placed 3 liters per minute (lpm) of oxygen via nasal cannula on the resident and her saturation levels went up to 77%. The DON said by the time the paramedics arrived, she was at 80%. The DON said the resident went to the ED around 4:45 a.m. on 12/29/24. She said the physician was contacted and he gave consent for the surgery. The DON said the police were contacted because adult protective services (APS) was notified of the incident. She said a son the facility was not aware of was also asking questions about the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 was interviewed on 3/5/25 at 6:05 p.m. CNA #3 said she was working on a different hall than Resident #1 resided on, on the night of 12/29/24. She said CNA #1 told her she was checking on Resident #1's roommate when she identified a bowel movement odor from Resident #1 which was not normal because Resident #1 would take herself to the bathroom when she needed to use the toilet and she would also change her own brief if it was soiled. CNA #3 said CNA #1 asked her for her assistance because she was not able to get Resident #1 up from the bed. CNA #3 said CNA #1, CNA #2 and RN #1 were already with the resident and trying to change her when she entered Resident #1's room. She said the resident would moan when they tried to turn her, but she was not yelling. CNA #3 said the biggest concern she saw was the resident was sweating profusely and was very out of breath. She said Resident #1 was not screaming out when they rolled her to change her brief. She said the resident just got very tense when she was moved. CNA #3 said Resident #1 was normally able to talk and say what she needed. CNA #3 said the NHA asked her some questions a week after the incident. She said after the resident was taken to the hospital, the four of them (CNA #1, CNA #2, LPN #1 and CNA #3) just spoke to each other about what happened. CNA #3 said Resident #1 took herself to bed that night. -However, according to the facility's 12/29/24 summary of events (see above), Resident #1 was toileted in the shower room by CNA #1 and CNA #2 and then assisted to her room and to bed on the evening of 12/28/24. The NHA was interviewed on 3/5/25 at 6:44 p.m. The NHA said CNA #1 had her competency training completed to include transfer training on 11/21/24. The NHA said CNA #2 did not have her competencies completed because she worked at the facility sporadically. CNA #1 was interviewed on 3/6/25 at 10:22 a.m. CNA #1 said Resident #1 took herself to the bathroom but she would sometimes need reminders. She said on the evening of 12/28/24 she walked Resident #1 to her room to go to bed. She said she noticed it took Resident #1 a little longer to walk than usual. She said the resident complained of some leg and hip pain. CNA #1 said Resident #1 was toileted around 8:00 p.m. She said at 10:00 p.m., she checked on her and reminded her to try to go to sleep. She said on 12/29/24 at 12:00 a.m. Resident #1 was sound asleep and her brief was dry. She said at 2:00 a.m the resident was making some noise so the CNAs encouraged her to get up to use the bathroom. CNA #1 said on 12/29/24 at 4:00 a.m. she entered the room to check on Resident #1's roommate and noticed Resident #1 needed to be changed. She said CNA #2 tried to move Resident #1's legs so she could to get up to use the bathroom but the resident screamed, which was not normal for Resident #1, so she went to get LPN #1. CNA #1 said she tried to swing the resident's legs off the bed and tried to stand her but she was dead weight so they laid her back down. She said Resident #1 started screaming again when they changed her brief in bed. She said the resident was drenched in sweat and her oxygen saturation levels were low. She said CNA #3 brought in the oxygen and a second nurse, LPN #2 also came in to the room to help them with Resident #1. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Rehabilitation and Healthcare Center	680 E Hospital Dr Cortez, CO 81321

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said she gave a verbal report of what happened to the NHA on the 12/29/24 night shift. She said she asked LPN #1 if there were any bruises she saw and she said no. CNA #1 said the staff was in shock because they never had seen Resident #1 in that condition. LPN #1 was interviewed on 3/6/25 at 10:53 a.m. LPN #1 said Resident #1 was fine on the evening of 12/28/24. LPN #1 said there were no reports of pain and she walked normally down to her room. She said the CNAs checked on her every two hours. She said when the staff went to get her up to get dressed, she started crying in pain. LPN #1 said she tried to get her up to see if she could bear weight but she could not stand. She said she assessed Resident #1 with range of motion and hip palpitations. She said she was able to look at the resident's skin a little bit but did not see any concerns. LPN #1 was interviewed again on 3/6/25 at 11:06 a.m. She said she did not see a bruise on her hip or leg but just remembered she saw a small lump on Resident #1's forehead that was about the size of a nickel with some bruise that was similar in coloring to her skin. She said she did not think the lump was new because a new bruise was usually bright purple. She said she did not document the lump on her forehead. RN #1 was interviewed on 3/6/25 at 1:42 p.m. She said the hospital ED called her and asked about a bruise on Resident #1 but she said she did not know anything about a bruise. She said she asked LPN #1 about the bruise and if anything happened before Resident #1 was sent to the hospital. RN #1 said nothing happened to cause the injuries that she was aware of. RN #1 said all the staff were surprised that Resident #1 had fractures and a bruise. RN #1 said Resident #1 would spend most of the day in a recliner in the living room or walk to her room or shower room to use the bathroom. She said no staff or residents reported any concerns to her. The NHA was interviewed again on 3/6/25 at 1:58 p.m. The NHA said she still thought Resident #1 did not fall and she ruled out abuse, because she watched the hall surveillance video and talked to staff. She said she did not interview other residents. Medical director (MD) #1 was interviewed on 3/6/25 at 3:47 p.m. MD #1 said the staff notified him that Resident #1 was sent to the hospital because she was in pain. MD #1 said the ED determined Resident #1 had bilateral hip fractures. MD #1 said he did not recall if Resident #1 had bruising along with the fractures but with that type of her injury, he would not be surprised if she had bruising. He said if one of the fractures was identified as a subacute fracture, it could indicate a fracture was potentially in the healing process. He said fractures could have easily occurred at Resident #1's age. The DON was interviewed on 3/6/25 at 4:14 p.m. The DON said she learned of the bruise on Resident #1's leg on the following morning (12/29/24) after the ED contacted the facility. She said she did not know which leg the bruise was found on or the size of the bruise. She said she was not aware of a lump on Resident #1's head or any other incidents that would have caused a lump on her head. The DON said she and the interdisciplinary (IDT) reviewed a resident when they sustained a change of condition, such as weight loss, falls and skin concerns. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she did not conduct a fall investigation after Resident #1's 12/29/24 incident. She said she did not feel Resident #1 fell but she did not know what happened to cause the injuries. She said she did not think Resident #1 could have fallen because she was found in bed and did not think she would have been able to get up and in bed after a fall. She said she did not know how or when the resident acquired the bruise. She said normally when there was a bruise of unknown origin, she would conduct an investigation. She said for bruise investigations she would look how the resident transferred, check if the resident was on blood thinners, look at furniture or equipment that could have caused the bruise and check past skin assessments. The DON said the staff were good about documenting and they did not see or document a bruise for Resident #1 before she was sent to the hospital so she was not aware of the bruise to the leg until the ED notified the facility. She said she did not conduct a bruise of unknown origin investigation after she was notified of the bruise on her thigh from the ED. The DON said a bruise may not always show up right away after a resident was injured. She said that was why they continued to monitor the resident and check for skin injuries 24 hours after a fall. The DON said she was not aware of a nickel-sized lump on Resident #1's forehead. She said nothing was reported to her or documented. The DON said she reviewed skin assessments prior to 12/29/24 and nothing indicated that the resident had a lump on her head or bruising. She said Resident #1 was sent out to the hospital because of pain, not because of an unknown injury. She said she needed to get more details about the incident by asking more questions and making sure staff documented any skin related concerns. The DON said the resident had weak bones and the fractures could have happened before 12/29/24, according to a coroner report conducted in January 2025. The NHA was interviewed a third time on 3/6/25 at 5:28 p.m. She said a fall investigation was not done after Resident #1's 1/23/25 incident because the facility did not feel there was a fall. She said a bruise of unknown origin was not investigated because the staff did not see the bruise and felt it did not happen at the facility. She said she checked to see if the resident was on blood thinners but she was not. She said she did not do a full abuse investigation because there was no indication of abuse. The NHA said she never figured out why the resident had an oxygen saturation level of 55% because she did not have respiratory problems. The NHA said she was not aware of Resident #1's lump on her forehead with slight coloring until the LPN #1 contacted her today (3/6/25). She said she would have conducted a fall investigation to see what had happened if she would have known about the lump on the forehead earlier. She said the lump could have been caused by a fall, however, she still felt Resident #1 did not fall. She said nothing was documented about the lump on her head. The NHA said a staff education regarding falls was conducted on 1/28/25 and 1/29/25, just in case Resident #1 injuries were a result of an undocumented fall that was not reported.

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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 (#2) of three residents reviewed for accidents out of three sample residents. Resident #2 admitted to the facility on [DATE] with a history of falls. Resident #2 sustained a fall on 11/21/24, 11/29/24, 1/4/25 and 1/23/25. After the resident sustained falls, the facility failed to implement timely interventions. On 1/23/25 the resident attempted to self transfer in the shower room where she fell and sustained a hip fracture. Review of Resident #1's electronic medical record (EMR) identified the facility failed to implement timely and effective interventions and ensure environmental hazards did not contribute to Resident #1's falls. Findings include: I. Facility policy and procedure The Accidents and Incidents-Investigating and Reporting policy, revised July 2017, was provided by the nursing home administrator (NHA) on 3/6/25 at 6:02 p.m. The policy read in pertinent part, All accidents or incidents involving residents, employees, visitors, vendors, occurring on premises shall be investigated and reported to the administrator. The policy identified the following steps that should be taken after the initial data was collected: The nurse supervisor/charge nurse and or the department director or supervisor shall complete a report of incident /accident form and submit the original to the director of nursing (DON) services within 24 hours of the incident or accident. The DON shall ensure that the administrator receives a copy of the incident/accident form on each occurrence. The incident/accident reports will be reviewed by the safety committee for trends related to the accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician's orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia, history of falling, generalized muscle weakness, abnormalities of the gate and mobility, need for assistance with personal care, cognitive communication deficit, difficulty walking and unspecified dementia, severe, without behavioral disturbance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 2/19/25 minimum data set (MDS) assessment documented Resident #2 had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. Resident #2 required substantial/maximal assistance from a sit to stand position and was dependent on staff for a toilet transfer. She 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 #2 had a history of falls. According to the MDS assessment, Resident #2 had two falls without injury and one fall with a major injury since her admission or in the past six months and one fall without injury since her last assessment. B. Record review The fall care plan, initiated 11/20/24 and revised 12/10/24, identified Resident #2 was at risk for falls related to bladder and/or bowel incontinence, generalized weakness, history of falls and needing assistance with activities of daily (ADL). The fall interventions, initiated on 11/20/24, directed staff to implement preventative fall interventions/devices, ensure call light was in reach and needed items were within reach, educate the resident how to use the call light and monitor her for changes in mobility. The fall interventions, initiated on 12/10/24, directed staff to provide Resident #2 with non-skid footwear, conduct physical therapy (PT)/occupational therapy (OT) and speech therapy evaluations, educate the resident and her family to call for assistance before transferring and provide food and drinks within reach. The fall interventions, initiated on 12/12/24, indicated Resident #2 was impulsive, over estimated her abilities and needed to be kept within line of sight. The 12/12/24 fall intervention directed staff to place her in a recliner. The 12/12/24 fall intervention, revised on 1/22/25, directed staff to place anti-roll backs on her wheelchair. The fall intervention, initiated on 1/7/25, identified Resident #2 was placed on a toileting program. -The facility failed to implement timely interventions after Resident #2 sustained a fall on 11/21/24, 11/29/24 and 1/23/25. 1. Fall on 11/21/24 - unwitnessed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall occurrence note, dated 11/21/24, identified Resident #2 was found on the floor in her room by a certified nurse aide (CNA). According to the note, Resident #2 was found on her back between the foot of the bed and the bathroom. The resident was toileted and brought to the nurse's station to keep within sight. The note documented the nurse completed a physical assessment to include range of motion. The resident was not able to move her right arm related to the presence of a right arm sling after a fall prior to her admission. The note documented the resident had a bump on the crown of her head but it was not known if the bump occurred at the time of the 11/21/24 fall or if the resident had the bump prior to her admission to the facility (11/20/24) from a fall at home. The note indicated the resident was not able to tell staff what happened other than she fell . Factors of the fall were identified as poor lighting and confusion. The 11/26/24 interdisciplinary team (IDT) meeting note identified Resident #2 was last toileted at 4:00 a.m. and checked at 4:45 a.m. The call light was in reach, her bed was in a low position, her wall light was on, she was incontinent at the time of the fall and was wearing socks. According to the note, the resident complained of shoulder and head pain. No other injuries were noted at the time of the incident. The nursing recommendation was to place the resident in a recliner in the line of sight. -The note did not identify if the socks the resident was wearing were non-skid or not. -The IDT note did not identify if the bump on her head occurred at the time of the 11/21/24 fall or if she had the bump from her last fall at home. -The review of the care plan did not identify new interventions were updated on the fall care plan until 12/12/24, three weeks after the 11/21/24 fall. 2. Fall on 11/29/24 - witnessed The 11/29/24 fall occurrence note identified Resident #2 had a fall. According to the note, a CNA observed Resident #2 attempting to transfer herself from her wheelchair to the recliner in the living room and she sat on the floor between two recliners. The resident had non-slip shoes on and her wheelchair was in front of her. The note indicated there were no injuries and she was placed in a recliner near the nurse's station. -The fall occurrence note identified Resident #2 was not placed in a recliner by staff as recommended in the 11/21/24 IDT note. The 12/3/24 IDT meeting note identified the recommendation after the fall was to implement a restorative program. -The restorative program for Resident #1 was not implemented until 12/13/24, two weeks after the fall (see interview below). -The review of the care plan did not identify that the restorative program was implemented as recommended on 12/3/24 by the IDT. 3. Fall on 1/4/25 - witnessed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/4/25 fall occurrence note identified Resident #2 was observed sliding from the recliner, down to the floor before staff could intervene. There were no injuries identified. According to the note, the resident stated she was going to the restroom. The 1/7/25 IDT note documented a video surveillance recording identified Resident #2 scooted herself over the edge of the recliner, walked around the foot rest, lost her balance and landed on her buttocks on the recliner foot rest which caused the recliner to tip forward. The resident slid down the foot rest and landed on the left side of her body. According to the note, there were no injuries and she denied any new or increased pain. The note indicated the resident did not ask to go to the restroom or was able to remember to ask for help. The nursing recommendations were to place the resident on a bowel and bladder toileting program. 4. Fall on 1/23/25 - unwitnessed The 1/23/25 fall occurrence note identified Resident #2 was found in a shower room on the floor at 7:45 a.m. The shower room door was propped open by a stool and unlocked. Resident #2 was laying on the floor on her right side with her pants pulled down below her knees. Her wheelchair was to the left of the resident and the brakes were unlocked. She was wearing non-slip shoes at the time of the fall. According to the note, during the nurse's physical assessment, the resident grabbed her right lower extremity in pain. Resident #2 had redness and light colored bruising to her right hip and a skin tear measuring 3 centimeters (cm) by 3 cm on her right knee. The note indicated the resident was sent to the hospital for an evaluation and treatment. The note documented the resident was last checked on at 7:40 a.m. Resident #2 was forgetful and overestimated her limitations. The bathing rooms were immediately locked. The 1/23/25 change in condition note identified Resident #2 returned to the facility with a diagnosis of a right femoral head fracture. Her family declined surgery. The note indicated the resident was on comfort-focused care. The note indicated the resident was attempting to crawl out of bed after returning from the hospital. The resident was placed in a recliner in view of the nurse's station due to her high fall risk. The 1/28/25 IDT meeting note identified staff were educated to keep doors locked for safety concerns as the nursing recommendation. -The fall care plan did not identify new care plan interventions were added after Resident #2 had another fall during a self-transfer that resulted in a broken hip (see care plan above). C. Education (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 1/23/25 staff education sheet was provided by the NHA on 3/6/25 at 6:17 p.m. The education sheet identified 75 staff members were educated to keep all of the doors in the hallways locked, except for the resident's rooms. It indicated doors could not be propped open or left unlocked for staff convenience. According to the provided education, leaving the doors open was extremely dangerous. Staff was expected to frequently check all the doors on the hallways to ensure the hallway doors were properly closed and locked. The education indicated that disciplinary action would be taken if the doors were not secured. The 1/28/25 staff education participation record on reporting was provided by the NHA on 3/6/25 at 6:02 p.m. According to the education record, 71 staff members were informed/reminded to report changes, loss of balance (without a fall), falls, slips, trips, physical contact, choking, behaviors or any change of condition in a resident to the nurse. The education record documented it was the nurse's responsibility to document and assess once it was reported to the nurse. III. Staff interviews The DON was interviewed on 3/6/25 at 4:14 p.m. The DON said after a fall she conducted a fall investigation. She said during a fall investigation, she would look for any injuries/skin issues and review prior skin checks. She said if there were new injuries, she would look at the resident's environment to see if there was anything that the resident could have bumped into. The DON said staff documented the details of each fall in the risk management incident report and a fall occurrence note. She said she and the IDT reviewed who found the resident and at what time, how the resident was found, including the position of the resident, what the resident was wearing on their feet at the time of the fall, what was the lighting in the fall location, when was the resident last checked on and last toileted, was the resident continent at the time of the fall, was the resident wearing oxygen if they had a physician's order, was the call light in reach at the time of the fall, was it witnessed, was there a head injury and who was notified after the fall. The DON said Resident #2's fall on 11/29/24 was witnessed by a CNA. The resident was self transferring to a recliner in the living room. When Resident #2 was last checked on, she was continent. She was wearing non-skid shoes and the lighting was dim. The DON said the intervention was to continue to work with restorative nursing. She said Resident #2 started on a restorative nursing program on 12/13/24 after her November 2024 falls. The DON said the fall on 1/4/25 happened at the nurse's station. The resident landed on her left side of her body. The DON said the nurse was alerted when she heard a noise. The DON said it was not documented if Resident #2 was continent at the time of the fall, when she was last toileted or when she was last checked on. She said it was not documented what the resident was wearing on her feet at the time of the fall. The DON said the resident was able to say she was trying to go to the bathroom at the time of the fall. She said a bowel and bladder program was added to Resident #2's care plan and the CNA communication sheet/Kardex on 1/7/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON said Resident #2's fall on 1/23/25 resulted in a hip fracture. She said the resident was found in the shower room lying on her right side. The DON said it was not documented what time the resident was last toileted other than it was on the night shift. She said the resident was last checked on at 7:40 a.m. She said she did not check if the resident was asked to use the toilet at 7:40 a.m. The DON said the resident normally needed assistance to use the toilet. She said she did not know who last checked on the resident before she fell . The DON said the resident was not able to say what happened or why she was in the shower/tub room but she assumed the resident was attempting to use the toilet because her pants were down and she was near the toilet. The DON said the door to the shower/tub room was propped open, allowing Resident #2 to enter the room. The DON said she did not know why the door was propped open and the light was on. The DON said the day staff said it was open when they arrived on shift. The DON said she questioned the night staff but no one could tell her why the door was left open. The DON said after reviewing the fall investigations, she felt she needed to ask more questions to get a better idea of all the fall details and what all happened. She said she saw areas where she could work on improving with her fall investigations. The NHA was interviewed again on 3/6/25 at 5:28 p.m. The NHA said Resident #2's fall on 1/23/25, which resulted in a hip fracture was because she self transferred herself to the toilet in the shower room. The NHA said Resident #2 used the toilet and then fell . The NHA said the door to the shower room should not have been left open for her to be able to enter. The NHA said the staff were educated to close and lock the doors. The NHA said falls were reviewed with the IDT and the new fall interventions were updated by the DON in the care plan within a week of the fall. CNA #4 was interviewed on 3/6/25 at 6:49 p.m. She said she worked with Resident #2 at night and would help other CNAs toilet her. She said she was not aware of a bowel and bladder toileting schedule for her, but she said Resident #2 was toileted every two hours, which was standard for any resident who needed assistance. The DON was interviewed again on 3/6/25 at 6:55 p.m. The DON said Resident #2 would try to get up and go to the bathroom by herself and not tell anyone. She said the care planned intervention bowel and bladder program for Resident #2 after her 1/4/25 fall meant she would be toileted every two hours. The DON said all residents were checked on every two hours.