STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065234	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Nursing Home	1991 Carroll St Alamosa, CO 81101

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents were kept free from physical abuse for five (#5, #7, #4, #2 and #3) of ten residents reviewed for abuse out of 12 sample residents.Resident #5 was admitted on [DATE] with diagnoses of Alzheimer's disease with behavioral disturbances. Resident #6 had a history of wandering and physical aggression. Resident #6 was admitted on [DATE] with diagnoses of dementia. Resident #5 had a history of physical aggression.On [DATE], Resident #6 and Resident #5 had a physical altercation, where the nurse observed Resident #6 push Resident #5. Resident #5 lost his balanced and fell and hit his head on a chair before he landed on the floor. The nurse observed Resident #5 bleeding from his head. The nurse progress note revealed Resident #5 was transferred to the emergency department for evaluation and treatment.Specifically, the facility failed to: -Protect Resident #5 from physical abuse by Resident #6;-Protect Resident #7 from physical abuse by Resident #8;-Protect Resident #2 and Resident #4 from physical abuse by each other; and, -Protect Resident #2 and Resident #3 from physical abuse by each other. Findings include:I. Facility policy and procedureThe Abuse prevention policy and procedure, reviewed [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:06 a.m. It read in pertinent part: It is the policy of this facility to prevent and prohibit all types of abuse. Identify, correct, and intervene in situations in which abuse is more likely to occur to include trained and qualified staff on each shift in sufficient numbers to meet the needs of the residents and ensure the staff assigned have knowledge of resident care needs and behavioral symptoms. Assure residents are free from neglect by having the structures and processes to provide needed care and services to all residents which included provisions of the facility assessment to determine what resources are necessary to care for its residents competently. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect; such as,-Verbally aggressive behavior;-Physically aggressive behavior;-Wandering into other's rooms/space;-Residents with communication disorders or who speak a different language; and,-Residents that require extensive nursing care and/or are totally dependent on staff for the provision of care.II. Incident of physical abuse by Resident #6 towards Resident #5 on [DATE]A. Facility investigationThe [DATE] facility investigation revealed an altercation occurred between Resident #6 and Resident #5 on the Cottage unit. The investigation revealed Resident #6 struck Resident #5 on the chest, that caused Resident #5 to fall. Resident #5 hit his head on a chair and sustained a laceration to the back of his head. The investigation revealed a registered nurse (RN) assessed both residents and determined Resident #6 had a four centimeter laceration on the back of his head and Resident #5 had no injuries. Resident #6 was transported to the emergency department and received eight staples to close the head laceration and then returned to the facility. The investigation revealed staff monitored both residents per facility policy and neither resident had a fear of each other and the victim did not recall the (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 0600 Level of Harm - Actual harm Residents Affected - Few	altercation. The investigation revealed a resident on the Cottage unit was interviewed and reported she had observed Resident #5 agitated throughout the day on [DATE]. The resident reported, Resident #5 was seen exit seeking and trying to get into other residents' rooms. The resident reported to the facility investigator that Resident #5 had been hitting, kicking and trying to open doors. The investigation revealed that a staff member attempted to intervene and stop the altercation between Resident #6 and Resident #5, however Resident #6 escalated his aggression towards Resident #5.The investigation documented the facility substantiated the incident of physical abuse. B. Resident 5 (victim)1. Resident statusResident #5, age greater than 65, was admitted on [DATE], discharged to the hospital on [DATE], was readmitted to the facility on [DATE], and expired on [DATE]. According to the [DATE] computerized physician's orders (CPO), diagnoses included Alzheimer's disease, dementia without behavioral disturbance, irritability and anger, mood disturbance, anxiety, abnormality of walking gait and mobility, muscle weakness, gout,and osteoarthritis.The [DATE] minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS). Resident #5 had short and long term memory problems and was severely impaired with making decisions that regarded his daily life. The assessment documented Resident #5 had continuous disorganized or incoherent thinking, with physical behaviors directed towards others for one of three days, verbal behaviors directed at others for one of three days, and other behavior symptoms not directed at others daily, and wandered daily.Resident #5 required set up assistance/touching assistance for personal hygiene, toilet transfers, eating, sitting up in bed, and standing. He required partial to moderate assistance for dressing and putting on/removing footwear. The assessment identified Resident #5 required supervision/touching assistance for transfers from chair to chair,was independent with ambulation and used a cane or crutch.2. Record reviewThe behavioral care plan, initiated [DATE], revealed Resident #5 had wandering and disruptive behaviors. Pertinent interventions included redirecting from potentially dangerous situations when wandering and removing from situations when he was disruptive. The dementia care plan, initiated [DATE], revealed Resident #5 entered other residents' rooms and was verbally/physically aggressive and had thrown objects. Pertinent interventions included administering medications as ordered, anticipating and meeting resident needs, intervening as necessary to protect the rights and safety of others, approaching in a calm manner, and redirecting the resident to an alternate location as needed. The [DATE] nurse progress note revealed Resident #6 and Resident #5 had physical altercation and the nurse observed Resident #6 push Resident #5. Resident #5 lost his balance, fell and hit his head on a chair before he landed on the floor. The nurse observed Resident #5 bleeding from his head. The nurse progress note revealed Resident #5 was transferred to the emergency department for evaluation and treatment. He sustained a four centimeter (cm) laceration to the back of his head. Resident #5, was sent to the hospital, where he received staples to the laceration.The [DATE] progress note documented Resident #5 had behaviors that included sitting on beds of other residents on the unit, swinging at staff while they tried to redirect him, and yelling at others residents on the Cottage unit. The progress note read that attempts to redirect Resident #5 were ineffective. The [DATE] social services director (SSD) progress note revealed Resident #5 had aggressive behaviors and wandered into other residents' rooms. New interventions were recommended to supervise and redirect Resident #5 and to help set up farming videos to redirect Resident #5. The [DATE] the physician increased medication buspirone to 10 milligrams twice daily for increased behaviors, agitation, physical and verbal aggression and exit seeking. C. Resident #6 (assailant)1. Resident statusResident #6, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included insomnia, dementia with other behavioral disturbances, history of falling, and Alzheimer's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	disease.The [DATE] MDS assessment revealed the resident had short and long-term memory problems and had a severe impairment to cognitive skills for decision making per staff assessment. Resident #6 had verbal behaviors directed at others for one to three days and other behavioral symptoms not directed at others for four to six days and had wandering behaviors.The assessment documented Resident #6 required supervision or touching assistance for showers and personal hygiene, and was independent with eating, dressing, putting on/off footwear, bed mobility, transfers, and walking.2. Record reviewThe dementia care plan, initiated [DATE], revealed Resident #6 had behavioral disturbances. Resident #6 wandered in the Cottage unit and believed another female resident was his mother. When agitated,/bored Resident #6 had disruptive behaviors of singing or talking loudly, hitting/clapping his hands together, stomping his feet, and laughing and pointing at other residents on the Cottage unit. Pertinent interventions included administering medications as ordered, discussing behavior with resident and explaining why his behavior was unacceptable, intervening as necessary to protect the rights and safety of others, approaching in a calm manner, and removing from a situation to redirect to an alternate location as needed ([DATE]), monitoring, redirecting, removing from the area if needed ([DATE]), and deescalating triggers by redirecting, offering a job/task to assist staff on the Cottage unit, and one-to-one conversation ([DATE]).The physical aggression care plan, initiated [DATE], revealed Resident #6 exhibited behavior of treating/fighting with other residents on the Cottage unit by putting his hands out, nodding, and commenting. Pertinent interventions included administering medications as ordered, analyzing times of day for triggers and circumstances to deescalate triggers of aggression, documenting behaviors and attempted interventions, and redirecting and walking away from sources of distress. The [DATE] nurse progress note revealed the nurse was called to the Cottage unit after the altercation between Resident #6 and Resident #5. Resident #6 was observed striking Resident #5, which caused Resident #5 to fall. Resident #5 fell and hit his head on a chair before landing on the floor. Resident #5 sustained a four cm laceration that was treated at the hospital.The [DATE] behavioral health physicians progress note revealed a concern for Resident #6's safety and the safety of staff and others on the Cottage unit due to repeated complaints of wandering at night and agitation and violence towards another resident. The progress note revealed previous efforts to redirect Resident #6 on the Cottage unit had not been successful.III. Incident of physical abuse by Resident #4 towards Resident #2 on [DATE]A. Facility investigationThe [DATE] facility investigation revealed a staff member entered the Cottage unit and heard raised voices. The staff member observed Resident #4 yelling at another resident while Resident #2 stood between Resident #4 and the other resident. During the verbal altercation, a staff member redirected and escorted the other resident from the altercation. One staff member remained with Resident #2 and Resident #4. As the staff member redirected Resident #2, Resident #4 reached out and grabbed Resident #2 by her shoulders and pulled her backwards quickly. Resident #2 responded with what appeared to the staff member as a defensive responsive and Resident #2 hit Resident #4 in the abdominal area with the back of her hand. The investigation revealed Resident #2 and Resident #4 were separated immediately and an assessment revealed neither resident was injured. The facility investigation revealed Resident #2 had a history of physical and verbal aggression and wandering. The investigation documented the facility substantiated the incident of physical abuse. B. Resident #2 (victim and assailant) 1.Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included Alzheimer's disease, dementia with other behavioral disturbances, anxiety, cognitive communication disorder, arthritis, osteoporosis, low back pain and had a surgical history of lumbar spine fusion.The [DATE] MDS assessment revealed Resident #2 was rarely understood and had a short and long term memory (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	problem. Resident #2 could normally find the location of her room, and had severely impaired skills for decision making. The assessment revealed Resident #2 had physical behavioral symptoms directed towards others that put others at significant risk for physical injury. The assessment revealed Resident #2 wandered on the unit for four to six days during the assessment period. The assessment revealed Resident #2 was independent for eating, completing toilet hygiene, dressing, bed mobility, transfers, and ambulation. Resident #2 required set up assistance from staff for oral hygiene and bathing. 2. Record reviewThe behavior care plan, initiated [DATE], revealed Resident #2 had behavior problems of wandering and sleeping in other residents' beds because of her dementia. Resident #3 had a history of physical aggression towards staff and other residents whether provoked or unprovoked. Pertinent interventions included administering medications as ordered ([DATE]), anticipating and meeting the resident's personal needs ([DATE]), monitoring all residents that wander and rummage, intervene as necessary to protect the rights and safety of others, diverting attention and removing from a situation to an alternative location as needed, and approaching and speaking in a calm manner ([DATE]), observing for behavior episodes and determining underlying causes, considering location and time of day ([DATE]), observing for wandering and preventing escalation of physical aggression by monitoring for escalation ([DATE]), monitoring behavior and observing for wandering with verbal or physical aggression ([DATE]), and educating staff on residents that exhibit aggressive behaviors are not to be left alone and or unattended ([DATE]).The physical aggression care plan, initiated [DATE], revealed Resident #2 had potential to be physically aggressive with others because of her dementia Pertinent interventions included administering medications as ordered ([DATE]), intervening before agitation escalates (12/2123), ensuring Resident #2 went into the correct room when showing signs of feeling upset, confused, or wandering, placing a large imprinted sign with her name outside of her room, and redirecting or escorting Resident #2 to her room as needed ([DATE]).The [DATE] nurse progress note revealed the nurse observed a staff member attempting to redirect Resident #4 and Resident #2. The nurse progress note revealed the nurse observed Resident #4 grab Resident #2 by the shoulder and pulled her backwards. The nurse progress note note read that Resident #2 appeared startled and in a defensive response, made contact with Resident #3's abdomen with the back of her hand. The nurse progress note read both residents were assessed and both appeared uninjured,The [DATE] SSD progress note revealed Resident #2 had no changes in her behavior or mood after the altercation with Resident #4 and participated in activities without fear of other residents. C. Resident #4 (victim and assailant) 1. Resident statusResident #4, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO diagnoses included shortness of Alzheimer's disease, epilepsy, anxiety, depression, bipolar disorder, and unspecified brain injury.The [DATE] MDS assessment revealed Resident #4 was unable to complete the BIMS. The assessment document Resident #4 had short and long term memory problems.The assessment documented Resident #4 had no behavioral symptoms directed at others and had physical and verbal behavior symptoms directed at others for one to three days during the assessment period.Resident #5 required partial to moderate assistance from staff for showering, set up assistance for hygiene, and was independent for eating, dressing, putting on/off footwear, bed mobility, transfers and walking.2. Record reviewThe [DATE] SSD progress note revealed Resident #4 had no changes in her behavior or mood after the altercation with Resident #2 and participated in activities without fear of other residents. IV. Incident of physical abuse by Resident #2 towards Resident #3 on [DATE]A. Facility investigation The [DATE] facility investigation revealed a staff member assisted Resident #2 to her bed and returned to the nurses desk at 9:25 p.m. The staff member documented minutes later she heard Resident #3 scream and then she ran to Resident #3's room. When the staff member entered (continued on next page)

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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** Based on record review and interviews, the facility failed to ensure that one (#5) of the three residents reviewed for accidents out of 12 sample residents remained free from accidents.Specifically, the facility failed to timely implement person centered fall interventions for Resident #5, who had multiple falls with major injury. Resident #5 was admitted on [DATE] with diagnoses of Alzheimer's disease and dementia. Resident #5 sustained a fall on [DATE] and on [DATE]. On [DATE] Resident #5 had a physical therapy evaluation that determined Resident #5 required supervision or touching assistance for ambulation. The change in level of assistance for ambulation was not communicated to nursing staff until [DATE]. During that time, Resident #5 sustained two more falls on [DATE] at [DATE]. After the fall on [DATE], Resident #5 was diagnosed with a subdural hematoma with a five millimeter midline shift (when brain tissue has sifted due to bleeding or swelling). On [DATE] Resident #5 sustained an additional fall. He was transferred to the hospital for evaluation and was diagnosed with a left hip fracture, fractures of the spine and multiple rib fractures. The resident returned to the facility on comfort care. Findings include:I. Facility policy and procedureThe Fall Management policy, revised [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:00 a.m. It revealed in pertinent part, The facility will assess the resident upon admission/readmission, with a change in condition and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. During the assessment, a care plan will be developed and initiated by the admitting nurse on any residents assessed to be at risk for falls. The interdisciplinary team (IDT) will review and revise the care plan if indicated upon a fall event. The interventions to reduce the risk of falls should be individualized based on the resident risk factors and fall history.II. Resident #5A. Resident statusResident #5, age greater than 65, was admitted on [DATE], discharged to the hospital on [DATE], was readmitted to the facility on [DATE], and expired on [DATE]. According to the [DATE] computerized physician's orders (CPO), diagnoses included subdural hematoma with midline shift, right hip fracture, head laceration, thoracic spine fracture, right rib fracture, Alzheimer's disease, dementia without behavioral disturbance, irritability and anger, mood disturbance, anxiety, abnormality of walking gait and mobility, muscle weakness, gout and osteoarthritis.The [DATE] minimum data set (MDS) assessment revealed the resident had short and long-term memory problems and had severe impairment in decision making skills per staff assessment. Resident #5 had continuous disorganized or incoherent thinking. He displayed behaviors directed at others. Resident #5 wandered daily.Resident #5 required set up assistance/touching assistance eating and transfers, supervision or touching for bed mobility, partial to moderate assistance for dressing, and Resident #5 was independent with ambulation.B. Record review1. Care plans and assessments The fall prevention care plan, initiated [DATE], revealed Resident #5 had a risk of falling. Pertinent interventions included orienting resident to his room ([DATE]), providing activities that minimize the potential for falls while providing diversion and distraction ([DATE]), referring for physical therapy as ordered, wearing a soft helmet at all times as tolerated ([DATE]), and proving adaptive equipment or devices as needed ([DATE]).\-However, the care plan did not reveal what adaptive equipment or device the resident needed.The [DATE] physical therapy evaluation and plan of treatment identified that resident #5. The evaluation identified that Resident #5 required set up assistance for walking ten feet, supervision or touching assistance for walking 50 feet and 150 feet. The fall prevention care plan was not updated to reflect the level of supervision Resident #5 required for ambulation. The evaluation on [DATE] was a change in condition from the Resident #5 previous level of function, when he could (continued on next page)

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	065234	A. Building B. Wing	02/05/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ambulate independently.2. Fall on [DATE] - witnessed The [DATE] nurse progress note revealed Resident #5 tripped on his feet while two staff members were assisting him to the restroom. The note documented Resident #5 displayed behaviors of agitation. Resident #5 fell to his knees and sustained a 2 centimeter (cm) by 2 cm and a 0.5 cm abrasion on his left knee. The nurse provided first aid to the resident and and Resident #5 had no complaints of pain. The [DATE] behavior huddle progress note recommended behavior interventions for supervision and redirecting.-However, the note did not include a post fall review or recommendations for fall prevention interventions.3. Fall on [DATE] - witnessedThe [DATE] nurse progress note revealed Resident #5 was struck by another resident and fell, hit his head on a chair, and landed on the floor. The nurse completed and assessment and found a 4 cm laceration on the back of Resident #5's head. Resident #5 was evaluated at the emergency department and the head laceration was closed with eight staples. The emergency department determined there were no additional injuries and Resident #5 returned to the facility on [DATE].There was no documentation the IDT reviewed the [DATE] fall and no fall prevention -interventions were recommended.Cross reference: F600 failure to protect residents from abuse.4. Fall on [DATE] - unwitnessedThe [DATE] 3:25 a.m. nurse progress note revealed Resident #5 was found by a staff member on the floor in his room. The progress not revealed Resident #5 either fell out of bed, or had been wandering in his room and fell. The completed an assessment and found a hematoma on the back of Resident #5's head on the right side. The nurse progress note read that Resident #5 wore big and bulky shoes when he fell. The progress note revealed the physician was notified and gave an order to monitor Resident #5. -There was no documentation the IDT reviewed the [DATE] fall and no fall prevention interventions were recommended.5. Fall on [DATE] - witnessedThe [DATE] 10:12 p.m. nurse progress note revealed Resident #5 had a fall in the hallway. The [DATE] fall investigation revealed Resident #5 had increased behaviors and the nurse attempted to redirect Resident #5 from a distance to sit on a chair. Resident #5 missed the chair and fell to the floor. The nurse completed an assessment and found a right forearm scratch and right elbow skin injury. The progress note revealed the physician was contacted and gave no orders. There was no documentation the IDT reviewed the [DATE] fall and no fall prevention interventions were recommended.The [DATE] 10:48 a.m. nurse progress note revealed Resident #5 had been combative and aggressive after the [DATE] fall. The physician was contacted and gave an order for a head computerized tomography scan to be completed at the hospital for head trauma. The progress note read the nurse arranged for the facility driver to transport Resident #5 to the hospital for the outpatient head computerized tomography scan. The [DATE] 7:42 p.m. nurse progress note revealed Resident #5 had a subdural hematoma found on the computerized tomography scan. The nurse progress note revealed staff would monitor Resident #5 and notify the physician if his condition worsened. The [DATE] nurse progress note revealed Resident #5 was provided a four wheel walker to assist with ambulation. The nurse progress note revealed Resident #5 did not do well with the walker and responded with aggression towards staff when they reminded him to use the walker. The progress note revealed the nurse thought the walker was a tripping hazard for Resident #5 due to his unwillingness to use the walker correctly. The [DATE] IDT post fall progress note revealed nursing made a request to the physician to add sleep medication for Resident #5 due to increased agitation at night. The physician declined the nursing request. -The IDT progress note had no additional fall prevention recommendations.6. Fall on [DATE] - unwitnessedThe [DATE] 1:50 p.m. nurse progress note revealed the nurse heard commotion from the hallway, went around the corner (from the nurses desk) and observed Resident #5 on the floor, on his back with his legs bent. The progress note revealed Resident #5 was in the hallway outside of his room. The nurse documented she heard Resident #5 as he yelled out in pain and observed him grabbing (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	his left hip and leg. The nurse notified the physician and the physician gave an order to for Resident #5 to be transferred to the emergency department for evaluation.The [DATE] hospital discharge summary revealed Resient #5 sustained a left hip fracture, multiple rib fractures, fractures of the 11 and 12 vertebrae of the thoracic spine, and was admitted to the hospital and treated for pain and anxiety from his recent fall that caused a subdural hematoma. The progress note revealed the hospital physician reviewed the fractures, severe dementia, and falls with Resident #5's family and the family agreed to complete comfort care. The [DATE] nurse progress note revealed Resident #5 returned to the facility. -There was no documentation the IDT reviewed the [DATE] fall and no fall prevention interventions were recommended.IV. Staff interviewsCertified nurse assistant (CNA) #3 was interviewed on [DATE] at 11:30 a.m. CNA #3 said she provided care and monitored residents behavior based on the CNA task assignments. CNA #3 said she checked on all residents during her shift. CNA #3 said she remembered helping Resident #5 with his helmet and that he had nonslip tape on the floor next to his bed. CNA #3 said Resident #5 did not remember to use his walker and did not seem to understand why to use the walker. CNA #3 said she did not know of any alternatives available for safe walking. She said Resident #5 walked around the Cottage unit by himself. CNA #3 said she tried to supervise every resident when they were out of their room but she frequently was off the hallway when she provided care to other residents.CNA #5 was interviewed on [DATE] at 11:36 a.m. She said she worked full time on the Cottage unit and provided care to residents. CNA #5 said after residents had fallen, the unit manager or nurse updated the CNA on the resident's status and changes in care needs. CNA #5 said she was not sure what interventions could be effective to prevent falls on the Cottage unit except for continuous monitoring of residents with high risk. CNA #5 said close and continuous monitoring was hard to provide due to the CNAs other tasks. CNA #5 said when she left the Cottage unit for her breaks, there was no one to step in and monitor or care for her assigned residents.The NHA and the social services director (SSD) were interviewed together on [DATE] at 2:21 p.m. The NHA said Resident #5 fell on [DATE] after an altercation where he was pushed by another resident. The SSD said Resident #5 sustained a laceration to his head and was treated at the hospital. The SSD said staff monitored Resident #5 after he returned from the hospital and he did not require changes to his fall prevention plan of care.The NHA said Resident #5 had a fall with a head strike on [DATE] after he missed sitting on a chair. The NHA said Resident #5 sustained a new hematoma on the back of his head and the physician recommended monitoring. The NHA said a root cause for the fall was completed and determined Resident #5 had poor safety awareness. The NHA said the resident fell while a staff member was verbally guiding him to sit on a chair. The NHA said staff Resident #5 was supervised by staff for his ambulation The SSD said Resident #5 had no changes to his behavior or assessment and a new intervention was made to involve Resident #5 with activities closer to his interest to divert him from wandering or agitation. The NHA said on [DATE] the staff assisted Resident #5 to his bed for rest after lunch and was later found on the floor by staff. The NHA said Resident #5 was left unattended and attempted to ambulate without assistance from staff.The director of nursing (DON) and the NHA were interviewed on [DATE] at approximately 2:00 p.m. She said the IDT reviewed falls in the facility. The DON said if the IDT recommended changes to a resident's care plan, it was updated by the unit manager or the MDS coordinator. The DON said care plan changes were communicated to nursing staff by holding huddle meetings in the unit to discuss new interventions or changes to resident care. The DON said after physical therapy evaluated Resident #5 and determined he required supervision or hands on assistance for ambulation, there was a breakdown or delay in communicating the changes with nursing staff. The DON said the changes were recommended on [DATE] and the change was not made until [DATE]. The (continued on next page)

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