STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065284	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Manor Care Center	465 5th St Burlington, CO 80807

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of two units.Specifically, the facility failed to:-Ensure staff followed the correct dwell time when using disinfectant to clean resident rooms and was not sprayed near resident's personal hygiene items; -Ensure housekeeping staff performed hand hygiene appropriately when cleaning resident rooms; and,-Ensure staff changed gloves after moving from dirty to clean task during wound care. Findings include: I. Professional reference According to the Center for Disease Control (CDC) About Hand Hygiene for Patients Healthcare Settings, 2/27/24 and retrieved on 4/27/26, Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. When should you clean your hands: Before preparing or eating food, before touching your eyes, nose, or mouth, before and after changing wound dressings or bandages, after using the restroom, after blowing your nose, coughing, or sneezing; and, after touching hospital surfaces such as bed rails, bedside tables, doorknobs, remote controls, or the phone. How should you clean your hands: with an alcohol-based hand sanitizer: Put the product on your hands and rub your hands together, cover all surfaces until hands feel dry. This should take around 20 seconds. With soap and water: Wet your hands with warm water. Use liquid soap if possible. Apply a nickel- or quarter-sized amount of soap to your hands. Rub your hands together until the soap forms a lather and then rub all over the top of your hands, in between your fingers and the area around and under the fingernails. Continue rubbing your hands for at least 15 seconds. Rinse your hands well under running water. Dry your hands using a paper towel. Then use a paper towel to turn off the faucet and to open the door if needed. II. Facility policy and procedure The Infection Control Guidelines for All Nursing Procedures policy, revised August 2012, was received from the NH) on 4/19/26. It documented in pertinent part, In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all of the following situations: (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
	065284	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Before and after direct contact with residents, before donning sterile gloves, before performing any non-surgical invasive procedures, before preparing or handling medications, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after handling used dressings or contaminated objects, after contact with objects in the immediate vicinity of the resident and after removing gloves. III. Housekeeping failures A. Facility disinfectant product specifications The Diversey Virex TB ready to use disinfectant cleaner product specification sheet, dated 2020, was provided by the nursing home administrator (NHA) on 4/20/26 at approximately 3:30 p.m. It read in pertinent part, The ready-to use disinfectant cleaner is a one-step cleaner and disinfectant for spray and wiping cleaning in health care and other facilities. It kills tuberculosis (TB) in five minutes, and all other bacteria in three minutes. It kills norovirus in 30 seconds. The product can be used in multiple areas, such as hospitals, health care facilities, medical offices, hotels, hotels, public restrooms, institutional facilities and schools. Use instructions: Spray area until it is covered with the solution. Allow the product to penetrate and remain wet: three minutes for all bacteria, five minutes for TB, one minute for HBV and HIV-1 and 30 seconds for norovirus. Air dry, wipe surfaces to dry and remove any resident or rinse with potable water as necessary. For heavily soiled areas, thoroughly clean the surface prior to disinfecting. B. Observations On 4/20/26 during a continuous observation from 9:58 a.m. to 10:17 a.m. the following was observed: At 10:07 a.m. housekeeper (HK) #3 placed her housekeeping supply cart outside room [ROOM NUMBER]. At 10:08 HK #3 donned (put on) a pair of single use gloves. HK #3 removed two towels from her housekeeping cart, then entered room [ROOM NUMBER]. She placed bottles of cleaner in the bathroom, and then removed the small trash bag from the trash can in the bathroom. HK #3 then emptied a small trash bag from a trash can by a bed in the room and placed them in a larger trash bag. At 10:12 a.m. there was a stack of clean white folded wash cloths on the sink and a yellow toothbrush on the sink and against the wall. HK #3 sprayed the cleaner on the sink and did not move the toothbrush or the hand towels. She immediately wiped the sink before letting the cleaner dwell on the surface. HK #3 sprayed the same chemical on the bedside tables in the room, then immediately wiped the tables and did not let the cleaner dwell on the surface. The cleaner was Diversy TB. C. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/21/26 at 12:21 p.m. CNA #4 said the washcloths were brought to the residents rooms after the shower aide was done in the afternoon, so the residents could have a washcloth for the night and the next morning. CNA #4 said toothbrushes were usually in a basin and were labeled. HK #2 was interviewed on 4/21/26 at 2:00 p.m. HK #2 said the chemical disinfectant was used to (continued on next page)

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	065284	A. Building B. Wing	04/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spray the bed, sink and toilet. She said after three minutes, the staff would go back and then wipe the areas. HK #2 said personal belongings should be put in a grey container. She said the container was picked up prior to spraying the disinfectant in the area, and the container set back down after spraying. The housekeeping supervisor was interviewed on 4/21/26 at 2:15 p.m. The housekeeping supervisor said the disinfectant had a three minute dwell time to ensure the bacteria and viruses were gone, and then wiped the disinfectant after three minutes. The housekeeping supervisor said beds, door knobs, side tables and any surface should be disinfected. She said all personal items should be removed prior to spraying chemicals and wiping it down because the chemical (residue) can get in the resident's mouth. The director of nursing (DON) was interviewed on 4/21/26 at 3:09 p.m. The DON said the chemicals dwell time was the time the cleaner was to set wet on the surface and then staff were supposed to wipe it off. The DON said resident belongings should be removed prior to spraying so the chemical did not get in the residents mouth or on their face. IV. Failure to use hand hygiene and glove use appropriately when cleaning resident rooms A. Observations During a continuous observation on 4/20/26, beginning at 9:30 a.m. and ending at 9:59 a.m., the following was observed: HK #1 was finishing cleaning resident room [ROOM NUMBER]. She said the room was already cleaned and she just needed to make the bed. She made the bed and then moved her cart to resident room [ROOM NUMBER]. Without performing hand hygiene, she donned (put on) clean gloves and cleaned the bathroom. She cleaned the high touch surfaces and the toilet. She got new rags and started to clean the bedroom. She moved around the personal items on the counter with a sink and wiped down the surfaces. She moved the items around again and wiped the mirror. She cleaned the high touch surfaces in the bedroom. She made the bed. She removed the soiled gloves and mopped the bedroom. -HK #1 did not use hand hygiene between resident rooms. -HK #1 did not use hand hygiene after removing soiled gloves. -HK #1 did not change gloves and use hand hygiene after touching a dirty (bathroom) area and before moving around and touching personal items and cleaning linen. B. Staff interviews The housekeeping supervisor was interviewed on 4/21/26 at 2:30 p.m. She said the housekeepers should be performing hand hygiene after each room before moving to another resident room. She said they should change gloves and wash hands between each area of cleaning the resident room, such as after cleaning the high touch surfaces, after cleaning the bathroom and after mopping. She said there could be cross contamination of germs if the housekeepers did not wash their hands. V. Failure to use hand hygiene and change gloves during wound care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Observations During a continuous observation on 4/20/26, beginning at 2:24 p.m. and ending at 2:30 p.m., the following was observed: Licensed practical nurse (LPN) #1 was going to provide wound care for a resident. LPN #1 gathered supplies and went into the resident's room. There were two CNAs in the room providing perineal care to the resident. LPN #1 washed her hands and donned clean gloves. She wiped the area of the wound with a wet wipe to clean her bottom where the wound was. LPN #1 applied the betadine to the wound, applied calcium alginate (wound dressing) and covered it with a foam dressing. -LPN #1 did not change gloves and perform hand hygiene after cleaning the dirty wound before applying a clean dressing. B. Staff interviews The DON was interviewed on 4/21/26 at 3:09 p.m. The DON said she was the facility's full time infection preventionist. She said she provided education to all staff on hand washing monthly during the in service meetings. She said she made sure staff follow hand hygiene by having them demonstrate and had no concerns with staff following hand hygiene practices. She said during wound care, gloves should be changed and hand hygiene should be completed after removing the soiled dressing and after the wound is cleansed. She said the importance of this was so the germs did not cross contaminate to someone else. She said the importance of changing gloves appropriately while cleaning a resident room was to not cross contaminate germs.

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	065284	A. Building B. Wing	04/21/2026

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the self-administration of medications was clinically appropriate for one (#8) of three residents out of 25 sample residents. Specifically, the facility failed to ensure:-An assessment was conducted to determine whether the self-administration of medications was clinically appropriate; and,-There was a secured place to store Resident #8's medications. Findings include: I. Facility policy and procedure The Self-Administration of Medications policy, reviewed February 2021, was received from the director of nursing (DON) on 4/21/26 at 6:58 p.m. It documented in pertinent part, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status. If the team determines that our resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.II. Resident #8A. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included type two diabetes, chronic heart failure and chronic kidney disease. The 3/30/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.B. Resident observation and interview Resident #8 was interviewed on 4/19/26 at 9:23 a.m. There was a cup on her bedside table that contained multiple. She said she wanted to go back to sleep. Resident #8 was interviewed again on 4/19/26 at 11:52 a.m. She was sitting up in a recliner chair. There was a bottle of eye drops, a bottle of dry mouth spray and a tube of triple antibiotic cream at her bedside table in front of her. She said she was approved by the doctor and nurses to be able to use the medications at her bedside because she had very dry eyes, nose and mouth. C. Record review A review of Resident #8's electronic medical record indicated no assessment completed for having medications at her bedside and being able to self-administer medication. The review also indicated no physician's order for self-administration of medication and nothing in the care plan for self-administering medication. D. Staff interviewLicensed practical nurse (LPN) #1 was interviewed on 4/20/26 at 1:45 p.m. She said the process they followed at the facility for when residents requested to self-administer medications included obtaining a physician's order, completing an assessment on the resident and getting a secured box for the medications to be stored in. LPN #1 was interviewed again on 4/21/26 at 10:30 a.m. She said a resident not properly assessed for self-administration of medication could be at a risk for taking over the recommended amount and potentially lead to harm for the resident. LPN #1 said another risk of residents having medications at their bedside is for wandering residents who have dementia. She said they could potentially get into the medication. The DON was interviewed on 4/20/26 at 4:20 p.m. She said when Resident #8 was admitted to the facility, she had over the counter medications in her room. The DON said the provider was notified and did not provide an order for the resident to self-administer medications. The DON said the medications were confiscated at that time. She said on 4/20/26, she was notified that Resident #8 had more over the counter medications on her bedside table. The DON said she found out that Resident #8's son brought them in for her and the DON confiscated the medications. The DON said she notified the provider and the resident's son to provide education not to bring them in. The (continued on next page)

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	065284	A. Building B. Wing	04/21/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON said in order for a resident to be able to self-administer medications, they needed an order from the provider, an assessment completed to ensure the resident could use the medication appropriately and a secured box in the room to store the medication so other residents could not get to the medication.

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	065284	A. Building B. Wing	04/21/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#16) of five residents reviewed for accidents out of 25 sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to ensure person centered fall interventions were consistently implemented for Resident #16, who sustained multiple falls Findings include: I. Facility policy and procedure The Fall Guidelines- Assessing Falls and Their Causes policy,reviewed October 2010, was received from the director of nursing (DON) on 4/21/26 at 6:58 p.m. It documented in pertinent part, The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall.Nursing staff, in collaboration with the interdisciplinary team will begin to try to identify possible or likely causes of the incident. They will refer to resident specific evidence. Nursing staff and the interdisciplinary team will evaluate chains of events or circumstances preceding a recent fall. This could include time of day of the fall, what the resident was doing, whether the resident was standing, walking, reaching or transferring from one position to another, whether the resident was trying to get to the toilet or whether any environmental risk factors were involved. Post fall physical head to toe evaluation should be conducted by the licensed nurse. If an individual falls, an incident report must be completed in a risk management portion of the electronic medical record. Notify the following individuals when a resident falls: the resident's family, the attending physician, the director of nursing services and the nursing supervisor on duty.II. Resident #16A. Resident status Resident #16, age greater than 65, was admitted on [DATE]. According to the April 2026 computerized physician orders (CPO), diagnoses included Friedreich ataxia (neurodegenerative disease causing weakness), muscle weakness, unsteadiness on feet, dementia and macular degeneration (vision loss). The 3/17/26 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for a mental status score of seven out of 15. She required maximal assistance with toileting, dressing, bathing and transfers. B. Observations and interview During a continuous observation on 4/20/26, beginning at 8:57 a.m. and ending at 9:40 a.m., the following was observed: At 8:57 a.m. Resident #16 was sitting in her wheelchair in her room by the closet. There was one water cup on the opposite side of the room on the night stand. At 9:36 a.m. CNA #2 came in and asked Resident #16 if she would like to get into her recliner. Resident #16 said she wanted to go home. The unidentified staff member assisted Resident #16 into the recliner and handed her a call light. The bedside table was next to Resident #16 with no water cup in reach. There was a water cup still on the night stand across the room. During a continuous observation on 4/20/26, beginning at 2:30 p.m. and ending at 4:10 p.m., the following was observed: At 2:30 p.m. Resident #16 was sitting in her recliner. The bedside table was next to her with no water cup. The call light was within reach. Resident #16 said she did not know how to call for help. There was a water cup on the opposite side of the room on her night stand. At 3:38 p.m.CNA #2 was walking around room to room collecting water pitchers. At 3:46 p.m. CNA #3 walked into Resident #16's room and had a conversation with her. At 4:00 p.m. CNA #2 dropped off Resident #16's water pitcher to her bedside table next to her. There was no water pitcher on her night stand anymore. -Staff failed to offer to toilet Resident #16 around the 3:00 p.m. time. C. Record review 1. Care planResident #16's fall care plan, revised 4/2/26, documented the goal of the care plan was to minimize the risk of falls with interventions. Pertinent interventions included assisting Resident #16 to the bathroom at approximately 3:00 p.m. daily (initiated 11/2/23) and putting two water cups in the room, one on the bedside table and one on the night stand (initiated 4/1/26). 2. Fall on 1/11/26-unwitnessed The 1/11/26 nursing note documented at 6:00 a.m., documented that staff reported Resident #16 was on the floor during this morning's rounds. The resident described she had rolled out of bed, stating she was not trying to get up. No injuries were noted. A new intervention was (continued on next page)

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	065284	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grace Manor Care Center	465 5th St Burlington, CO 80807

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented to place pillows on the bed to define the edges of the bed (which was later removed). 3. Fall on 1/15/26- unwitnessed The 1/15/26 nursing note documented at 11:43 a.m., documented that staff alerted the nurse that the resident was on the floor. Resident #16 did not know what she was doing and she needed the bathroom but that was not the reason she was getting up. No injuries noted. A new intervention was to remove Resident #16's wheelchair from within her reach to avoid the urge to self-transfer (which was later removed). 4. Fall on 3/16/26- unwitnessed The 3/16/26 nursing note documented at 4:30 a.m., documented that the aides found the resident laying on the floor along the side of her bed during rounds. Her head was facing the sink and feet were at the edge of the bed. She was laying on her left side with her arm tucked under her. She did not have footwear on. She was alert and at her normal baseline which was confused but she could answer questions. A 5 centimeter skin tear was noted on her left forearm and was cleaned and dressed. The resident stated she was just messing around. A new intervention was implemented to re-educate staff to keep the bed in the lowest position. 5. Fall on 3/26/26- unwitnessed The 3/26/26 nursing note documented at 6:30 p.m., documented that walking rounds were done at 6:00 p.m. At that time, Resident #16 was at her sink in her wheelchair washing her face. Another resident's caregiver had heard Resident #16 yelling for help and checked on her to find her laying on the floor. The caregiver alerted the staff. Resident #16 was unable to give a description of what happened. No injuries noted. A new intervention was implemented to offer assistance with evening cares. 6. Fall on 4/1/26- unwitnessed The 4/1/26 nursing note documented at 3:45 p.m., documented that the nurse was sitting at the south nurse's station when a resident was heard calling out for help. Upon the nurse's arrival to the resident's doorway, the resident was on the floor laying on her left side with feet pointed north and head south. The resident described to the nurse and two CNA's that she crawled out of her bedside chair, crawled around the bed on her stomach because she was so thirsty and she just had to get to her water. The water glass was noted to be on the night stand. There were no injuries noted. A new intervention was implemented to put one water cup by her chair on the bedside table and one on the night stand. -However, there was only one water cup implemented on the night stand (see observations above). D. Staff interviews CNA #3 was interviewed on 4/20/26 at 4:10 p.m. She said Resident #16 was a fall risk because she tried to get out of bed without assistance and she was confused. CNA #3 said for intervention to help prevent Resident #16 from falling, the staff check on her more frequently on days she is more confused, they use nonskid footwear, the call light within reach and keep the door open. Licensed practical nurse (LPN) #1 was interviewed on 4/20/26 at 10:30 a.m. She said Resident #16 was a fall risk and interventions they have in place included a fall mat at night, trying to keep her in activities during the day, transfer her to the recliner chair instead of leaving her in her wheelchair in her room and trying to not leave her alone. LPN #1 said Resident #16 liked to stay busy and always do something. LPN #1 said new interventions are sent out in a text message alert and also an alert on the computer. The DON and the regional clinical resource nurse were interviewed together on 4/21/26 at 11:45 a.m. The DON said Resident #16's cognition had declined quite a bit over the last couple months. She said she had macular degeneration, but still tried to be as independent as she could. The DON said Resident #16 is a fall risk due to her diagnosis of dementia, vision problems and her muscle weakness. The DON said her current fall interventions included placing water on both sides of the bed, making sure her stuff was within reach, nonskid strips on the floor, getting her dressed and ready for bed, offering the bathroom around 3:00 p.m. (because she fell once at that time going to the bathroom), family and the facility to help out with her holiday cards, a reacher, making sure the bedside table was locked, therapy to evaluate, pink tape on her call light, pink balls on her wheelchair brakes and a sign on her closet to call for help. The DON said all staff were responsible for ensuring interventions are in place.