STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Health and Rehabilitation Center	51 Sunrise Blvd Saint Augustine, FL 32084

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident and staff interviews, a review of facility and resident records, and a review of the facility's policies and procedures titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation, and Turning and Positioning the Residents, the facility failed to protect the resident's right to be free from neglect/deprivation of services by Certified Nursing Assistant (CNA) A. The facility failed to ensure sufficient safeguards and supervision to protect the resident's right to be free from neglect by failing to ensure that CNA A was aware of, and implemented, care plan interventions to prevent one resident (#1) from an avoidable fall with major injury (hip fracture), from a total of four residents reviewed for Activities of Daily Living (ADLs) assistance.On February 3, 2026, the facility neglected to ensure adequate supervision to prevent Resident #1, who required two-person assistance with bed mobility, from falling out of bed and sustaining a hip fracture due to CNA A's failure to follow the resident's care plan, and instead, providing care by herself. The resident was rolled onto his side by CNA A while she provided care. The resident's leg slipped over the side of the bed and the weight of it pulled him out of bed onto the floor. He sustained a hip fracture from the fall and had to be admitted to an acute care hospital for further treatment. Immediate Jeopardy (IJ) at a scope and severity of J (Isolated) was identified at 1:15 PM on March 4, 2026.On February 3, 2026 at 2:00 PM, Immediate Jeopardy began.On March 5, 2026 at 5:30 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on March 5, 2026.The findings include:Cross reference F689.A review of Resident #1's medical record revealed an admission date of 7/29/16 with a re-entry on 2/9/26. His diagnoses included displaced intertrochanteric fracture of the right femur (hip fracture), subsequent encounter for closed fracture with routine healing, peripheral vascular disease (circulation disorder caused by narrowed, blocked, or spasmodic blood vessels, most commonly affecting the legs and feet), myelodysplastic syndrome (blood cancer causing fatigue and shortness of breath among other symptoms), obesity (excessive body fat accumulation), lymphedema (damage in the lymph system causing swelling, usually in the arms and legs that can lead to heaviness, pain and restricted movement), seizures, major depressive disorder, attention-deficit hyperactivity disorder (neurodevelopmental condition characterized by persistent patterns of inattention, hyperactivity, and impulsivity), hereditary and idiopathic neuropathy (nerve disorder causing symptoms like muscle weakness, pain, and numbness in feet/hands), and rheumatoid arthritis with rheumatoid factor (chronic autoimmune disease that produces an antibody that attacks healthy joint tissue, causing inflammation, pain, and stiffness).A review of the resident's active physician's orders revealed:Air mattress - ordered 4/7/25.Venlafaxine (antidepressant) 37.5 mg (milligrams) every day for depression - ordered 1/7/26. Gabapentin (used to treat nerve pain and partial seizures) 300 mg (milligrams) every 8 hours for neuropathy - ordered 2/10/26.Lasix (diuretic) 40 mg two times a day (BID) for fluid retention - ordered 2/10/26.Levetiracetam (Keppra - antiepileptic medication for treating seizures) 500 mg every 12 hours for seizures - ordered 2/10/26.Surgical incision to right hip. Change dressing as needed. Cleanse with normal saline and cover with nonstick island dressing - ordered 2/10/26 upon re-entry after the resident's 2/3/26 fall (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	with hip fracture.Morphine 15 mg every 6 hours for pain - ordered 2/18/26 upon re-entry after the resident's 2/3/26 fall with hip fracture.Transfers with Hoyer lift (mechanical lift for someone who is dependent for transfers) with 2-person assist - ordered 2/19/26, 10 days after Resident #1's re-entry following his 2/3/26 fall with hip fracture and subsequent hospitalization.A review of the resident's active care plan (revised on 12/23/25) revealed that the resident had the potential for falls related to his seizure history, a history of placing himself on the floor once upset and raising his bed to the highest position by himself. Interventions included providing 2-person assistance with bed mobility, floor mats to both sides of the bed, and 2-person assistance for transfers.A review of the annual minimum data set (MDS) assessment with an assessment reference (ARD) of 12/09/25 revealed that the resident had a brief interview for mental status (BIMS) score of 14 out of 15 possible points, indicating intact cognition.A nursing progress note dated 11/3/25 revealed that Resident #1 had a witnessed fall. As the CNA was providing morning care by herself, she turned the resident on his left side, and he slid out of bed onto the fall mat at bedside. He denied pain or discomfort at the time of the fall, no apparent injuries were noted, no new skin issues were noted, and neuro checks (quick, focused assessments used to monitor a resident's brain function, nervous system and neurological status over time) were within normal limits. The resident was assisted back to bed using a Hoyer lift. A nursing progress note dated 11/4/25 revealed that the interdisciplinary team (IDT) met and reviewed the 11/3/25 fall. [Resident #1] fell out of bed while being cleaned up. Resident to have 2 aides to perform care while in bed.A nursing progress note dated 2/3/26 at 2:15 PM revealed: CNA was in the room providing care to the resident. Resident was rolled to the side of the bed and began having a bowel movement. At that time, he let go of the side rail and began falling off the bed. Resident was hanging onto the bedrail with his bottom half on the floor, ROM (range of motion) performed as tolerated in the current position. Resident was assisted back into bed via Hoyer lift (mechanical lift) and 4 staff members. Once in bed resident C/O (complained of) pain to his right hip. Spoke with NP (nurse practitioner) and X-ray of right hip ordered. DON (Director of Nursing) and RP (responsible party) notified.A nursing progress note dated 2/3/26 at 3:53 PM revealed: X-ray completed and shows a FX (fracture) of the right hip. Spoke with NP who gave new order to send to ER (emergency room) for further eval. (evaluation) Daughter updated.A review of the Imagining Report, dated 2/3/26, revealed right hip 2 view findings:Acute transverse fracture proximal femur. 1 cm (centimeter) medial displacement humeral shaft. Femoral head is anatomically situated within the acetabulum with moderate femoral acetabular joint degenerative changes. Mineralization is decreased. Vascular calcifications. Impression: Acute transverse fracture proximal femur (sudden break in the upper part of the thigh bone, just below the hip joint).In an interview on 3/4/26 at 1:25 PM with CNA A, she stated she had been employed by the facility for seven months. She said she was hired as an Activities Assistant but occasionally assisted on the nursing unit when there was a staffing shortage. When she was asked how she identified residents' needs, she stated she was more familiar with the residents in the Memory Care unit, as she was assigned to provide activities on that unit. She said she would check the residents' care plans and ask the nurse or another CNA who was familiar with the residents. When she was asked if she was familiar with Resident #1, she replied that she did not know him too well. She stated 2/3/26 was the first time she worked with him. On that day, the facility had two staff members who called out, and she was not notified ahead of time that she would be working on the nursing unit until she arrived at the facility at 8:00 AM (Her normal work time was 8:00 AM to 5:00 PM.). When she was figuring out where she was assigned, other staff had already passed the breakfast trays. As she walked to her assignment, she noted that there were three residents on her assignment who required assistance with eating their meals, so she started assisting them. She said, Normally staff review the care plan needs at the beginning of the shift, but on that day, I was already late and the previous staff had already left. I didn't have time to review the care plans. She stated she briefly asked the other CNAs on the unit to provide a rundown of the residents assigned to her. There were two CNAs (She could not recall their names.) who did not (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mention that Resident #1 required 2-person assistance for bed mobility. At approximately 2:00 PM, she went to the resident's room to provide care. She turned the resident toward the window. Resident #1 was holding onto the siderail and his legs flipped out of bed (he had large legs). His lower body being heavier than his upper body pulled him down and he landed on his buttocks. CNA A called the nurse who conducted an assessment. The resident was then assisted back into bed with a Hoyer lift. While in bed he complained of hip pain and an x- ray was ordered.On 3/4/26 at 1:41 PM, Resident #1 was observed in bed. He stated he always had two staff members assist him with turning/repositioning and bed mobility. He confirmed that on 2/3/26, only one staff member provided the care. He explained that CNA A turned him toward the window too fast and he slid off the bed near the wall. The resident stated he was not provided with any instructions or preparation by CNA A that she was about to turn him. He said, It happened so fast. I remember being turned and the next thing I remember was I was on the floor. A joint interview was conducted with the Director of Nursing (DON) and the Administrator on 3/4/26 at 2:15 PM. They were asked how staff were expected to identify resident needs. The DON stated staff should review the care plan at the beginning of the shift and also get a report from the previous shift staff at the beginning of each shift. When they were asked about Resident #1's 2/3/26 incident, they said that on 2/3/26 at 2:00 pm, CNA A went to the resident's room to provide ADL care. She rolled the resident on the bed toward the window. The resident was holding onto the side rail. At approximately 2:12 PM, as CNA A was providing incontinent care, the resident's feet slid off the bed because he had large legs (lymphedema). The weight of his lower body pulled his upper body out of bed onto the floor. The resident's legs hit the floor first and his upper body was still off floor as he was holding onto the side rail. The CNA notified the nurse who conducted an assessment. Resident #1 complained of hip pain and an x- ray was ordered. The results of the x-ray revealed an acute transverse fracture of the right femur. The resident was sent to the ER for an evaluation. He was admitted to the hospital and surgery was performed. An investigation was initiated immediately. CNA A was given one-to-one education about reviewing the resident's care plan before providing care and was then suspended pending the investigation. When they were asked for the findings of their investigation the DON stated the allegation of neglect could not be substantiated because CNA A was newly assigned to Resident #1 and was not aware of his needs. The DON and the Administrator were given the facility's policy on abuse and neglect so they could review the policy's definition of neglect. The facility's policy reflected the federal abuse and neglect regulation. They stated they would review the policy and get back with the surveyor.In a follow-up interview with the DON and the Administrator on 3/4/26 at 4:31 PM, they stated CNA A was newly assigned to Resident #1 and was not aware of the level of assistance required for the resident's bed mobility. They reiterated that CNA A was unfamiliar with Resident #1 as she did not normally work on that nursing unit. They stated CNA A told them that she received report from staff working on the unit who explained to her that Resident #1 was alert and oriented, and was able to communicate his needs, which was consistent with a resident who required one-person assistance for bed mobility. Therefore, they felt there was no intent to harm the resident, so there was no neglect. The federal abuse/neglect regulation and its definition of neglect, as well as the facility's abuse/neglect policy, were reviewed with the DON and the Administrator. Both voiced understanding of the definition of neglect.On 3/5/26 at 1:10 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) B who stated she had been employed by the facility for two years. She confirmed that she was Resident #1's assigned nurse on 2/3/26. She said the CNA (CNA A) approached her in the hallway and stated she needed assistance because the resident was on the floor. Upon entering the room, the resident was observed on the left side of his bed. He was holding his upper body off the floor by grasping the side rail and his lower body was on the floor in a twisted angle. The assigned CNA (CNA A) stated she was providing incontinent care and when she turned the resident on his side, he rolled out of bed. The CNA was alone while providing care. LPN B stated Resident #1 required two staff members for bed mobility due to his obesity and lymphedema. Resident #1 was assisted onto the floor, an assessment (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was completed (by LPN B) and no injuries were identified. The resident was then assisted back into bed with the help of three staff members and the use of a Hoyer lift. When the resident was placed back in bed, he complained of right hip pain. LPN B contacted the resident's physician and obtained a STAT (immediate) order for an x-ray. She then notified the Unit Manager and Resident #1's family.A review of the facility's policy and procedure titled Turning and Positioning the Residents (Policy Number: NP. I-88, Effective Date: 10/01/2010), revealed:Process:I. Turning and Repositing Procedurea) Explain the procedure to the resident and ask permission to proceed.b) Use two persons for this procedure as needed.c) If the resident is in bed, turn the resident to the desired position and use pillows or cushions to keep the resident comfortably in place, if needed. A review of the facility's policy and procedure titled Abuse, Neglect, Misappropriation of Resident/Guest Property, Suspicious Injuries of Unknown Source, Exploitation (Policy Number NM. II-20, Effective Date: 10/15/2022), revealed:Purpose:This policy is concerned with all incidents and accidents involving resident(s)/guest(s). All of our resident(s)/guest(s) have the right to be free from abuse, neglect, exploitation and misappropriation of resident/guest property.Page 4 of 12 - Section B NeglectNeglect is a failure of the facility or its employees or service providers to provide goods and services necessary, to attain or maintain physical, mental, and psychosocial well-being to avoid physical harm, mental anguish, or emotional stress when the facility knew or should have known to provide the goods and/or services but continued to fail to take the actions necessary.Neglect may include, but is not limited to: Leaving residents/guests to sit or lie in urine or feces without appropriately intervening, isolating dependent residents/guests by leaving them in their rooms or other isolated locations (apart from temporary separation occurring in the context of assessment and care planning), deliberate failure to answer call bells to provide needed assistance and performing one-person assistance to transfer a resident/guest when they are care planned for two persons. Failure to implement an effective communication system across all shifts for communicating necessary care and information between staff, practitioners, and resident representatives may result in neglect.Serious Bodily Injury is defined as an injury consisting of extreme physical pain involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation, or an injury resulting from criminal sexual abuse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 resident and staff interviews, a review of facility and resident records, and a review of the facility's policy and procedure titled Turning and Positioning the Residents, the facility failed to ensure that residents received adequate supervision and staff assistance to prevent avoidable falls with major injury (hip fracture) for one (Resident #1) of four residents reviewed for Activities of Daily Living (ADL) assistance.On 2/3/2026, Resident #1, who required 2-person assistance for bed mobility, sustained a fall from bed with a subsequent right hip fracture while Certified Nursing Assistant (CNA) A was providing peri-care. The CNA, working alone, turned the resident on his side in bed. The resident's leg slipped off the side of the bed pulling him to the floor. LPN B assessed the resident with no injuries immediately identified. Three staff members assisted the resident back into bed with the use of a Hoyer lift. The resident then complained of right hip pain. The physician was notified, and new orders were received for a STAT x-ray of the right hip. The x-ray results were positive for acute transverse fracture of the right femur (hip fracture), and the resident was sent to the hospital for further evaluation and surgery. Immediate Jeopardy (IJ) at a scope and severity of J (Isolated) was identified at 1:15 PM on March 4, 2026.On February 3, 2026, Immediate Jeopardy began.On March 5, 2026 at 5:30 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on March 5, 2026.The findings include:Cross reference F600.A review of Resident #1's medical record revealed an admission date of 7/29/16 with a re-entry on 2/9/26. His diagnoses included displaced intertrochanteric fracture of the right femur (hip fracture), subsequent encounter for closed fracture with routine healing, peripheral vascular disease (circulation disorder caused by narrowed, blocked, or spasmodic blood vessels, most commonly affecting the legs and feet), myelodysplastic syndrome (blood cancer causing fatigue and shortness of breath among other symptoms), obesity (excessive body fat accumulation), lymphedema (damage in the lymph system causing swelling, usually in the arms and legs that can lead to heaviness, pain and restricted movement), seizures, major depressive disorder, attention-deficit hyperactivity disorder (neurodevelopmental condition characterized by persistent patterns of inattention, hyperactivity, and impulsivity), hereditary and idiopathic neuropathy (nerve disorder causing symptoms like muscle weakness, pain, and numbness in feet/hands), and rheumatoid arthritis with rheumatoid factor (chronic autoimmune disease that produces an antibody that attacks healthy joint tissue, causing inflammation, pain, and stiffness).A review of the resident's active physician's orders revealed:Air mattress - ordered 4/7/25.Venlafaxine (antidepressant) 37.5 mg (milligrams) every day for depression - ordered 1/7/26. Gabapentin (used to treat nerve pain and partial seizures) 300 mg (milligrams) every 8 hours for neuropathy - ordered 2/10/26.Lasix (diuretic) 40 mg two times a day (BID) for fluid retention - ordered 2/10/26.Levetiracetam (Keppra - antiepileptic medication for treating seizures) 500 mg every 12 hours for seizures - ordered 2/10/26.Surgical incision to right hip. Change dressing as needed. Cleanse with normal saline and cover with nonstick island dressing - ordered 2/10/26 upon re-entry after the resident's 2/3/26 fall with hip fracture.Morphine 15 mg every 6 hours for pain - ordered 2/18/26 upon re-entry after the resident's 2/3/26 fall with hip fracture.Transfers with Hoyer lift (mechanical lift for someone who is dependent for transfers) with 2-person assist - ordered 2/19/26, 10 days after Resident #1's re-entry following his 2/3/26 fall with hip fracture and subsequent hospitalization.A review of the resident's active care plan (revised on 12/23/25) revealed that the resident had the potential for falls related to his seizure history, a history of placing himself on the floor once upset and raising his bed to the highest position by himself. Interventions included providing 2-person assistance with bed mobility, floor mats to both sides of the bed, and 2-person assistance for transfers.A review of the annual minimum data set (MDS) assessment with an assessment reference (ARD) of 12/09/25 revealed that (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	she would check the residents' care plans and ask the nurse or another CNA who was familiar with the residents. When she was asked if she was familiar with Resident #1, she replied that she did not know him too well. She stated 2/3/26 was the first time she worked with him. On that day, the facility had two staff members who called out, and she was not notified ahead of time that she would be working on the nursing unit until she arrived at the facility at 8:00 AM (Her normal work time was 8:00 AM to 5:00 PM.). When she was figuring out where she was assigned, other staff had already passed the breakfast trays. As she walked to her assignment, she noted that there were three residents on her assignment who required assistance with eating their meals, so she started assisting them. She said, Normally staff review the care plan needs at the beginning of the shift, but on that day, I was already late and the previous staff had already left. I didn't have time to review the care plans. She stated she briefly asked the other CNAs on the unit to provide a rundown of the residents assigned to her. There were two CNAs (She could not recall their names.) who did not mention that Resident #1 required 2-person assistance for bed mobility. At approximately 2:00 PM, she went to the resident's room to provide care. She turned the resident toward the window. Resident #1 was holding onto the siderail and his legs flipped out of bed (he had large legs). His lower body being heavier than his upper body pulled him down and he landed on his buttocks. CNA A called the nurse who conducted an assessment. The resident was then assisted back into bed with a Hoyer lift. While in bed he complained of hip pain and an x- ray was ordered.On 3/4/26 at 1:41 PM, Resident #1 was observed in bed. He stated he always had two staff members assist him with turning/repositioning and bed mobility. He confirmed that on 2/3/26, only one staff member provided the care. He explained that CNA A turned him toward the window too fast and he slid off the bed near the wall. The resident stated he was not provided with any instructions or preparation by CNA A that she was about to turn him. He said, It happened so fast. I remember being turned and the next thing I remember was I was on the floor. A joint interview was conducted with the Director of Nursing (DON) and the Administrator on 3/4/26 at 2:15 PM. They were asked how staff were expected to identify resident needs. The DON stated staff should review the care plan at the beginning of the shift and also get a report from the previous shift staff at the beginning of each shift. When they were asked about Resident #1's 2/3/26 incident, they said that on 2/3/26 at 2:00 pm, CNA A went to the resident's room to provide ADL care. She rolled the resident on the bed toward the window. The resident was holding onto the side rail. At approximately 2:12 PM, as CNA A was providing incontinent care, the resident's feet slid off the bed because he had large legs (lymphedema). The weight of his lower body pulled his upper body out of bed onto the floor. The resident's legs hit the floor first and his upper body was still off floor as he was holding onto the side rail. The CNA notified the nurse who conducted an assessment. Resident #1 complained of hip pain and an x- ray was ordered. The results of the x-ray revealed an acute transverse fracture of the right femur. The resident was sent to the ER for an evaluation. He was admitted to the hospital and surgery was performed. An investigation was initiated immediately. CNA A was given one-to-one education about reviewing the resident's care plan before providing care and was then suspended pending the investigation. When they were asked for the findings of their investigation the DON stated the allegation of neglect could not be substantiated because CNA A was newly assigned to Resident #1 and was not aware of his needs. The DON and the Administrator were given the facility's policy on abuse and neglect so they could review the policy's definition of neglect. The facility's policy reflected the federal abuse and neglect regulation. They stated they would review the policy and get back with the surveyor.In a follow-up interview with the DON and the Administrator on 3/4/26 at 4:31 PM, they stated CNA A was newly assigned to Resident #1 and was not aware of the level of assistance required for the resident's bed mobility. They reiterated that CNA A was unfamiliar with Resident #1 as she did not normally work on that nursing unit. They stated CNA A told them that she received report from staff working on the unit who explained to her that Resident #1 was alert and oriented, and was able to communicate his needs, which was consistent with a resident who required one-person assistance for bed mobility. Therefore, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105315	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Augustine Health and Rehabilitation Center	51 Sunrise Blvd Saint Augustine, FL 32084

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	they felt there was no intent to harm the resident, so there was no neglect. The federal abuse/neglect regulation and its definition of neglect, as well as the facility's abuse/neglect policy, were reviewed with the DON and the Administrator. Both voiced understanding of the definition of neglect.In a telephone interview on 3/5/26 at 12:51 PM, Licensed Practical Nurse (LPN) C/Unit Manager stated she had been employed by the facility almost five years. She was asked how she ensured that resident care was provided when there was a staffing shortage. She explained that the facility had a staffing coordinator who was responsible for staffing during the day and an on-call person during off hours. She stated during this time the staff on the nursing unit would be divided and assigned to all residents until additional coverage was found. When she was asked about the staffing on 2/3/26, she stated she was notified that there was a staffing shortage due to call outs. The staffing coordinator notified her that the Activities Assistant would be assisting on the unit. LPN C contacted the Director of Activities and asked her to notify the Activities Assistant when she reported to work that she would be working on the nursing unit. When LPN C was asked about Resident #1's care needs, she stated he required 2-person assistance for bed mobility and that this had been the case for several months. She confirmed that she was on duty on 2/3/26 when Resident #1 fell. She explained that the nurse assigned to Resident #1 (LPN B) notified her that the resident was on the floor after sustaining a fall during care and he complained of hip pain. She went to the resident's room. The resident was already back to bed. She stated she did not interview the resident but asked the assigned CNA (CNA A) what happened. She then notified the Director of Nursing (DON). When she was asked how staff were expected to identify residents' care needs, she replied that they were expected to review the point of care in the electronic medical record at the start of the shift. When she was asked if CNA A was familiar with Resident #1, she said CNA A worked as an Activities Assistant, but she was provided with the training about how to review the care plan before providing care to the residents.On 3/5/26 at 1:10 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) B who stated she had been employed by the facility for two years. She confirmed that she was Resident #1's assigned nurse on 2/3/26. She said the CNA (CNA A) approached her in the hallway and stated she needed assistance because the resident was on the floor. Upon entering the room, the resident was observed on the left side of his bed. He was holding his upper body off the floor by grasping the side rail and his lower body was on the floor in a twisted angle. The assigned CNA (CNA A) stated she was providing incontinent care and when she turned the resident on his side, he rolled out of bed. The CNA was alone while providing care. LPN B stated Resident #1 required two staff members for bed mobility due to his obesity and lymphedema. Resident #1 was assisted onto the floor, an assessment was completed (by LPN B) and no injuries were identified. The resident was then assisted back into bed with the help of three staff members and the use of a Hoyer lift. When the resident was placed back in bed, he complained of right hip pain. LPN B contacted the resident's physician and obtained a STAT (immediate) order for an x-ray. She then notified the Unit Manager and Resident #1's family.A review of the facility's policy and procedure titled Turning and Positioning the Residents (Policy Number: NP. I-88, Effective Date: 10/01/2010), revealed:Process:I. Turning and Repositing Procedurea) Explain the procedure to the resident and ask permission to proceed.b) Use two persons for this procedure as needed.c) If the resident is in bed, turn the resident to the desired position and use pillows or cushions to keep the resident comfortably in place, if needed. A review of the facility's policy and procedure titled Person-Centered Care Plans (Policy Number: NM.III-8, Effective Date: 08/15/2018), revealed:PURPOSE:Person-centered plans of care are developed by the interdisciplinary team, to coordinate and communicate care approaches and goals of the resident/guest, consistent with the resident/guests) rights.STANDARD:According to federal regulations, the facility develops and implements a baseline plan of care within 48 hours of admission that includes the minimum healthcare information necessary to properly care for the immediate needs of the resident/guest.According to federal regulations, the facility develops a comprehensive person-centered plan of care for each resident/guest that includes measurable objectives and (continued on next page)

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