STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105546	A. Building B. Wing	11/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Orange Health and Rehabilitation Center	1730 Lucerne Terrace Orlando, FL 32806

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 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** 43192 Based on observation, interview, and record review, the facility failed failed to ensure a resident was assessed to self-administer medication safely for 1 of 1 residents reviewed for self-administration of medications, of a total sample of 14 residents, (#4). Findings: Resident #4 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis following a stroke affecting the left non-dominant side, and contractures of his left and right knees. Review of the Minimum Data Set quarterly assessment with Assessment Reference Date of 8/30/24 revealed resident #4 had a Brief Interview for Mental Status score of 15 out of 15 which indicated he was cognitively intact. Review of resident #4's Admit/Readmit Screener evaluation dated 6/02/24 revealed he was his own responsible party. Review of the care plan revealed a focus for, At risk for decrease ability to perform ADLS (Activities of Daily Living) . revised on 9/25/24. One of the interventions instructed nurses to, monitor medications, especially new/changed/discontinued, for side effects and resident's response contributing to cognitive loss/dementia, including all medications, drug interactions, adverse drug reactions drug toxicity, or errors. On 11/07/24 at 10:34 AM, a pill was seen on resident #4's bedside table next to him. He stated it was vitamin C he, neglected to take it this morning and explained he had his, own vitamins. He pointed to 4 bottles of vitamins in a basket on the nightstand table next to his bed. He stated he had Vitamin C, Kelp, Ginkgo Biloba, and something else he could not recall. He stated his nurse was aware he had vitamins with him. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 10:44 AM, Licensed Practical Nurse (LPN) G stated resident #4 was alert and oriented, not confused, and was able to express his needs. LPN G indicated the resident was not able to self-administer his own medications. She explained when she passed his medications, she waited for him to take them before leaving his room. She explained upon admission, residents signed a form accepting that the facility nurses would provide all their medications. She indicated if she saw any medications at the bedside, she would remove them from the resident's room. She stated she gave resident #4's medications except a Lidocaine patch this morning because he was going to take a shower. At 11:01 AM, LPN G and the surveyor entered resident #4's room and she validated there was a pill on the bedside table and 4 bottles of vitamins in a basket on the nightstand next to his bed. LPN G explained to resident #4 she needed to remove the bottles and discard the pill on the bedside table since she did not know what it was. She told him she would discuss the vitamins with the physician and if ordered, she would administer those with his other prescribed medications. She told him she was taking the bottles of Gingko Biloba, Calcium, Vitamin C, and Kelp, along with the pill found at the bedside table. Resident #4 stated he was frustrated, and did not want to be treated like a baby. Upon exiting resident #4's room, LPN G stated she was not aware he had the bottles with him. She read the labels on the bottles: Vitamin C 1000 milligrams (mg); Calcium 600 mg + Vitamin D3; Ginkgo Biloba- no strength, 2 capsules equivalent to 500 mg; [NAME] 1000 mg. She discarded the unidentified pill. She indicated vitamins could interact with prescribed medications and must be ordered by the physician. She said, It is dangerous, not a good thing for the resident to take vitamins/minerals without the physician's knowledge. She validated he had not been assessed to self-administer the supplements by himself and they were not included in his active medications. On 11/07/24 at 11:26 AM, the Director of Nursing (DON) stated self-administration of medication was done according to the cognition of the resident. She stated residents could self- administer medications, but it was not encouraged. She validated the Interdisciplinary team would assess a resident to determine if they could self-administer medications and they would need a physician's order. The DON could not explain why there were 4 bottles of Vitamins/Minerals and a pill lying on resident #4's bedside table without the facility's knowledge. On 11/07/24 at 4:07 PM, Certified Nursing Assistant (CNA) H indicated he saw the bottles of vitamin in resident #4's room before today and assumed he had permission to have them. He recalled resident #4 was transferred to this assignment about 3 weeks ago and he came with those bottles. He stated he did not ask the resident or the nurse about the vitamins he saw. He mentioned he should not have assumed and should have told the nurse. On 11/09/24 at 12:08 PM, the North Wing Unit Manager (UM) stated she never noticed the vitamins/minerals in resident #4's room. She explained he ordered a lot of stuff online and the Activities staff assisted him to open the packages because he had contractures on his left arm. She indicated they did their best to check what he ordered. The UM explained they were supposed to discuss resident #4's preference with the provider and ensure the vitamins/minerals were ordered. She explained the medication self-administration process included residents signing a document included in the admission packet and the care plan would reflect this after the provider approved it. On 11/08/24 at 2:22 PM, the Administrator stated resident #4 was not supposed to have bottles of vitamins/minerals in his room. She indicated the physician, and/or the nurse did not know he had them. She explained the staff was aware residents should not have medications including vitamins/minerals in their possession and should tell the nurse if they saw any at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident Self-Administration of Medications policy and procedure dated 11/2020 indicated a resident would only self-administer medications after the facility's Interdisciplinary team had determined which medications could be self-administered safely. The policy continued that, The results of the Interdisciplinary team assessment are recorded on the Self-administration of Medication Evaluation, which was located in the resident's medical record. The policy described that all nurses and aides were required to report to the charge nurse on duty any medication(s) found at the bedside not authorized for bedside storage and the care plan must reflect the resident self-administered medications and have safe storage arrangements.

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F 0600 Level of Harm - Minimal harm or potential for 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** 32131 Based on interview, and record review, the facility neglected to provide the appropriate care and services after a fall with injury for 1 of 2 residents reviewed for neglect, of a total sample of 14 residents, (#12). Findings: Resident #12, an [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included wedge compression fracture of the lumbar vertebra, repeated falls, generalized weakness, functional quadriplegia, and dementia. Review of the resident's clinical records revealed a physician's order dated 10/17/24 for the resident to be sent out to the hospital for further evaluation and treatment on 9/03/24 after a fall. Review of the resident's MDS assessment dated [DATE] revealed resident #12 was rarely/never understood and had short- and long-term memory problem. The assessment noted the resident was dependent on the assistance of staff for toileting hygiene, to roll left and right, transfer from sitting to lying, and for chair/bed-to chair transfer. A progress note documented by Licensed Practical Nurse (LPN) B dated 9/03/24 read, Was notified by CNA (Certified Nursing Assistant) that resident was on the floor, upon entering the room observed resident has redness to the right side of her eye and chin area. Upon assessment vital signs were taken. Assisted resident back to bed, notified [Advance Practice Registered Nurse (APRN)] order to send resident out for further evaluation. On 11/06/24 at 9:50 AM, the South Wing Unit Manager (UM) stated she was out of the facility on the date of the incident with resident #12. She recalled she received a phone call regarding the incident but could not recall the details. The UM stated the resident had a minor injury, an investigation was initiated by the Administrator, and the resident's assigned CNA was suspended. On 11/08/24 at 11:47 AM, the Administrator stated the incident with resident #12 was on 9/03/24, and she was notified by the Director of Nursing (DON) on 9/04/24, after a clinical review revealed a resident went out to the hospital after a fall. She stated that investigation, `identified that resident #12 had a fall out of bed on 9/03/24 at 8:30 PM as per interview with the resident's assigned CNA but was not reported to the resident's assigned nurse until 10:15 PM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator verbalized that resident#12's assigned CNA reported that he heard noise coming from resident #12's room, and the resident's roommate was asking for help. She explained that the resident's assigned CNA, CNA D verbalized that he physically picked resident #12 up off the floor and placed her in bed. The fall code, Code Star was not initiated, and the CNA did not inform the resident's assigned nurse and left the resident's room. Approximately one hour and forty-five minutes later CNA D asked CNA E to accompany him into the room to check on the resident, who had sustained a laceration over her right eyebrow. CNA E asked what happened to the resident and was told by CNA D that he picked the resident up off the floor and placed her in bed. The Administrator said CNA E reported her observation to the resident's assigned nurse LPN B, who evaluated the resident, contacted the provider, and resident #12 was sent to the hospital for further evaluation. The Administrator stated that based on the investigation, the facility classified the incident as neglect, and on 9/04/24, CNA D was placed on administrative suspension and was terminated on 9/12/24. However, as of 11/08/24, the facility had not reported the CNA to the Board of Health. On 11/09/24 at 7:59 AM, in a telephone interview LPN B stated she worked on the 3:00 PM to 11:00 PM shift, and recalled she was resident #12's primary nurse on 9/03/24. LPN B recalled the resident fell from her bed, the assigned CNA did not report the fall to her but picked the resident up off the floor and returned her to her bed. She stated another CNA informed her, she could not recall if it was at the change of shift, when the oncoming CNA was doing her walk around report, that she noticed the bruise to the resident's face, and reported the findings to her. LPN B stated she went into the resident's room, observed the resident, and noted a bruise to the right of the resident's face. She documented the findings, notified the physician, and received an order to send the resident out to the Emergency Department(ED) for further evaluation. LPN B recalled she spoke to CNA D, who said the resident rolled out of bed. She recalled she asked CNA D why he did not report the resident's fall to her, and the CNA said he was afraid to tell her, he did not want her to get mad. The statement documented by LPN B dated 9/03/24 read, was notified by CNA that resident had fallen . observation noticed resident right side her face was red. Complete assessment was done notified APRN and proper management. Sent resident to hospital for evaluation. On 11/09/24 at 8:12 AM, in a telephone interview, CNA E, stated she recalled that on 9/03/24, she worked a double shift, from 3:00 PM to 7:00 AM. She recalled she was doing rounds at approximately 7:00 PM-8:00 PM, when resident #12's assigned CNA asked her for help to reposition the resident. CNA E stated she noticed a bruise on the resident's face, and she asked CNA D what happened, and he said he did not know. The CNA said she went to get the nurse and asked her if she was aware of the bruise on the resident's face, the nurse said no, she had given the resident medication earlier, and there was no bruise. CNA E said she asked LPN B to come and observe the resident, and the nurse asked CNA D what happened. CNA E recalled she left the resident's room, and when LPN B came out of the resident's room she heard her saying why didn't you report it. CNA E stated resident #12 would be included in her assignment on the 11:00 PM-7:00 AM shift, and she wanted to be sure that the nurse was aware of her observation. CNA E's statement dated 9/03/24 revealed that while doing rounds after 8:00 PM assigned CNA asked for assistance to pull up the resident in bed. noticed bruises on one side of her face, asked assigned CNA what happened was told he don't know. So, I reported to the nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted with CNA D on 11/09/24 at 11:17 AM, with translation provided by Spanish speaking Surveyor. The CNA stated he worked at the facility for approximately nine months and was resident #12's assigned CNA on 9/03/24. He recalled that at approximately 8:30 PM, he had completed a shower for another resident, and when he went to place the dirty linen in the soiled utility room, he heard the resident's roommate calling for help because she wanted to be changed. He recalled resident #12 was on the floor, and he saw redness around the left side of the resident's face. CNA D, said he did not recall if a mechanical lift was required for transfer of the resident, but he was able to transfer her, and he lifted her up off the floor back into bed. He said he did not follow the Code Star procedure, and after about twenty-five to thirty minutes, he asked another CNA if the marks the resident had were old. He recalled CNA E told the nurse, and the nurse and CNA E checked the resident. He said the nurse asked him what happened, and he told her the resident had fallen, and he had picked her up. The nurse told him he needed to report that fall immediately, and he was supposed to let the nurse know before picking the resident up. He was suspended and later terminated. CNA D's statement dated 9/03/24 read, when I walked in because the next bed calling. I found (resident #12) on the floor on the right side of the bed . was left face down . face sideways, with a blow to the mouth. The statement did not document any actions taken by CNA D after resident #12 was found on the floor. Review of the ED Provider Note dated 9/03/24 revealed the resident was in the ED for 3 hours, and read, Patient sustained an unwitnessed ground level fall at her nursing home tonight .trauma to her right orbital. A care plan for Activities of Daily Living self-care performance deficit created on 8/23/24 with revision on 9/05/24, had interventions which included that the resident required total assistance by two staff with bed mobility, and with transfers using a mechanical lift. The facility's Fall Program instructions on what to do when a fall occurs included, that the Nurse on duty should call a Code Falling Star, assess/evaluate the resident for pain, signs of injury, bleeding, changes in level of cognition, and if no injury was suspected, the resident should be assisted, back to bed or wheelchair via minimum of a 2 person assist or [mechanical] lift.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview, and record review, the facility failed to conduct a thorough investigation pertaining to a fall with fracture for 1 of 7 residents reviewed for falls, of a total sample of 14 residents, (#2). Findings: Resident #2, a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included traumatic subdural hemorrhage, altered mental status, cognitive communication deficit, schizophrenia, history of falling, and difficulty walking. Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was severely impaired, with a Brief Interview For Mental Status score of 06 out of 15. The assessment noted the resident required substantial/maximal assistance of staff for personal hygiene, and chair/bed-to chair transfer. Physician orders dated 9/20/24 was for stat (immediate) x-ray 2 Views of the left hip and left leg. Physician order on 9/24/24 was for stat anterior-posterior lateral 4 views x-ray of the resident's bilateral hips, and 2 views x-ray of the lumbar spine, due to history of fall. Another order on 9/24/24 was to send the resident out to the hospital for CT (Computed tomography) scan due to conflicting X-ray results A progress note documented by Registered Nurse (RN) A dated 9/20/24 at 11:48 PM, read, Nurse call to room by staff @ 1600 hr (4:00 PM). Observed resident sitting on floor. Head to toe assessment completed, no visible injury noted at this time . Resident complaint of L (left) hip, L leg, and L wrist pain, Tylenol administered . Resident assisted to wheelchair. Resident stated, 'I was walking from my Table (bed) to my wheelchair when I fell .' [Advanced Practice Registered Nurse [(APRN)] notified, Labs ordered: X ray 2 views L femur, . lt wrist . Neuro check started. Review of the results of the X-ray on 9/20/24 of the Left femur/tibula /fibula, and left wrist showed no fracture, and no acute bone abnormality. Progress note documented by the South Wing Unit Manager dated 9/24/24 at 11:55 AM, read, Reported by staff that resident was complaining of pain during therapy. Resident states, it's pain all down here from my thigh to leg . Resident assisted back to bed and given Tylenol for relief. APRN made aware and agrees with STAT hip and thoracic spine x-ray for further evaluation. Review of the X- ray results on 9/24/24 of the resident's bilateral hips showed a fracture of the femoral neck without significant displacement or angulation, and read, this demonstrates interval change since prior exam. There is osteoporosis and degenerative joint disease . studies compared 9/20/2024. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/08/24 at 10:17 AM, the incident was reviewed with the Administrator and the Director of Nursing. The Administrator acknowledged that she was the facility's Risk Manager, and said on 9/20/24, resident #2's family visited and left the resident in her room, and at 4:31 PM, the resident was found on the floor in her room, and on assessment, she complained of pain to her left hip and left wrist. She stated the physician was notified, and staff received physician order for left hip and left wrist x-ray, and neuro checks. The Administrator verbalized that the x-ray results on 9/20/24 showed no acute bone abnormality, and no fracture, and follow up was recommended if the resident's pain persisted. She stated a second set of x-rays were done of the resident's bilateral hip, and left spine on 9/24/24 after the resident complained of pain in therapy. The result showed osteoporosis, mild degenerative disease of the left hip, and a fracture of the femoral neck without significant displacement or angulation, and resident #2 was sent out to the hospital for further imaging. The Administrator stated the resident's family called back a day or so later and said the resident had a fracture. The Administrator stated an investigation of the resident's fall was done, the resident's assigned nurse RN A, and the assigned Certified Nursing Assistant (CNA) were interviewed. She stated resident #2 was not interviewed due to her cognition, and telephone call with the resident's family confirmed that he left her in her room then left the facility after his visit. She stated the facility determined that the root cause of the fall, was that the fall was caused by her family leaving the resident in her room. The Administrator stated she did not recall if the facility's camera footage for 9/20/24 was reviewed to identify the time the resident was placed in her room, and the time the family left the facility. She acknowledged that an immediate or five-day State Agency Nursing Home Federal Report was not completed or submitted regarding the fall with fracture, Elder Affairs and/or Law Enforcement were not notified, because their Root Cause Analysis was that the family took the resident into her room without staff knowledge. On 11/08/24 at 3:25 PM, RN A acknowledged that on 9/20/24, she was resident #2's primary nurse. The RN recalled that on the day of the incident she came in to work at 3:00 PM, and it was reported to her that the resident was outside in the courtyard with her family. She stated that while standing at her medication cart in the hallway, she observed the resident's family member pushing the resident in her wheelchair into her room. The RN stated the family member left, and approximately forty-five minutes later a CNA told her the resident was on the floor. RN A could not recall which CNA reported the incident to her, and when she went into the resident's room, she saw resident #2 sitting on the floor between the bed and the closet. The RN recalled she assessed the resident, and she did not complain of pain at that time, but thirty minutes later, she started to complain of pain, the physician was notified, and imaging was done of the left hip and wrist. The results indicated there was no fracture. She recalled she asked all the staff present who transferred the resident to her bed, and they all denied putting her to bed. The RN said she was not aware the resident had a fracture. On 11/09/24 at 10:19 AM, the Administrator stated she called the resident's family on 9/23/24, and the family member confirmed he placed resident #2 in bed. However, she did not recall asking the family member what time he placed the resident in bed. The Administrator stated she believed that there was always room for improvement, in regards to the facility's investigation. She acknowledged that although the facility investigation concluded the root cause of resident #2's fall with fracture was the family took the resident to her room without staff knowledge, it was ultimately staff responsibility to be aware of where the resident was. She said staff should know where a resident was at all times to ensure they were safe. The Administrator stated, an investigation was done, and staff did not know the resident was in her room. The Administrator said staff on duty reported they did not place the resident in bed, and staff should have been aware of where the resident was at all times. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/09/24 at 11:52 AM, the Administrator provided the facility's Visitor Log, which revealed the resident's family member signed in on 9/20/24 at 2:10 PM, and signed out at 4:00 PM. The facility's policy Fall Prevention Program implemented 11/01/20, and reviewed/revised 10/18/22 read, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility's policy Abuse, Neglect and Exploitation, implemented 11/03/20 and reviewed/revised 7/2023 instructed that in investigating different types of alleged violations, the facility should be, Identifying and interviewing all involved persons, including the alleged victim .witnesses, and others who might have knowledge of the allegations .Providing complete and thorough documentation of the investigation.

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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** 32131 Based on interview, and record review, the facility failed to provide adequate supervision to prevent a fall with fracture for 1 of 7 residents reviewed for falls, of a total sample of 14 residents, (#2). Findings: Resident #2, a [AGE] year-old female was admitted to the facility on [DATE]. Her diagnoses included traumatic subdural hemorrhage, altered mental status, cognitive communication deficit, schizophrenia, history of falling, and difficulty walking. Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident's cognition was severely impaired, with a Brief Interview For Mental Status score of 06 out of 15. The assessment noted the resident required substantial/maximal assistance of staff for personal hygiene, and chair/bed-to chair transfers. Section J of the assessment revealed resident #2 had a fall in the last two to six months prior to admission and a fall without injury and a fall with non major injury since admission. Review of the Morse Fall Scale assessments conducted for the resident revealed the resident was assessed as being at moderate risk for falling on 8/06/24 with a score of 40, and was at high risk for falling on 8/11/24, and on 9/20/24 with a score of 75. The Morse Fall Scoring revealed that a score of 45 and higher indicated the resident was at high risk for falling, and a score of 25-45 indicated the resident was at moderate risk for falling. Review of the facility's incident log for the period July 2024 to current revealed the resident had an unwitnessed fall on 8/02/24 at 2:55 PM, the resident was observed in a sitting position near the foot of her bed. The resident said she was trying to walk. Intervention implemented, was to place bed in low position. On 8/11/24 at 9:30 AM, the resident was observed on the floor between the beds in a seated position. The resident stated she was trying to go brush her teeth. Intervention implemented was for frequent checks, and an intervention for bilateral bolsters to the bed was added on 8/12/24. A progress note documented by Registered Nurse (RN) A dated 9/20/24 at 11:48 PM read, Nurse call to room by staff @ 1600 hr (4:00 PM). Observed resident sitting on floor. Head to toe assessment completed, no visible injury noted at this time . Resident complaint of L (left) hip, L leg, and L wrist pain, Tylenol administered . Resident assisted to wheelchair. Resident stated, 'I was walking from my Table (bed) to my wheelchair when I fell .' [Advanced Practice Registered Nurse (APRN)] notified, Labs ordered: X-ray 2 views L femur, . lt wrist . Neuro check started. Review of the results of the X-ray on 9/20/24 of the left femur/tibula /fibula, and left wrist showed no fracture, and no acute bone abnormality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105546	A. Building B. Wing	11/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Orange Health and Rehabilitation Center	1730 Lucerne Terrace Orlando, FL 32806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note documented by the South Wing Unit Manager dated 9/24/24 at 11:55 AM, read, Reported by staff that resident was complaining of pain during therapy. Resident states 'it's pain all down here from my thigh to leg' . Resident assisted back to bed and given Tylenol for relief. ARNP made aware and agrees with STAT hip and thoracic spine x-ray for further evaluation. Review of the X- ray results on 9/24/24 of the resident's bilateral hips showed a fracture of the femoral neck without significant displacement or angulation, and read, this demonstrates interval change since prior exam. There is osteoporosis and degenerative joint disease .studies compared 9/20/2024. On 11/08/24 at 9:13 AM, the South Wing Unit Manager (UM) recalled resident #2 was fairly new to the unit, was admitted from the hospital to the facility for a fall at a previous facility and was assessed as being at risk for falls. She recalled that during the resident's stay in the facility, she had some falls, and with the last fall, the resident was sent back to the hospital. She shared that the resident's family member was attempting to transfer her from bed to restroom, and she spoke with the family regarding transferring the resident without asking staff for assistance. On 11/08/24 at 10:30 AM, the falls were discussed with the Administrator and Director of Nursing (DON). The Administrator stated family was told by staff not to leave the resident in her room by herself since she was impulsive, and believed she could walk without assistance. She stated that when the resident was admitted to the facility, she was bedfast, but with therapy she was again able to walk, but needed assistance. When asked how often frequent checks were done, the Administrator stated that frequent checks were typically every two hours. On 11/08/24 at 3:25 PM, RN A acknowledged that on 9/20/24, she was resident #2's primary nurse. The RN recalled that on the day of the incident she came in to work at 3:00 PM, and it was reported to her that the resident was outside in the courtyard with her family. She stated that while standing at her medication cart in the hallway, she observed the resident's family member pushing the resident in her wheelchair into her room. The RN stated the family member left, and approximately forty-five minutes later a CNA told her that the resident was on the floor. RN A could not recall which CNA reported the incident to her, and explained when she went into the resident's room, resident #2 was sitting on the floor between the bed and the closet. The RN recalled she assessed the resident, and although she did not complain of pain at that time, thirty minutes later she started to complain of pain, the physician was notified, imaging done of the left hip and wrist, but there was no fracture. She recalled she asked all the staff present, who transferred the resident to her bed, and all denied putting her into bed. She verbalized that the resident had a history of attempting to get up out of bed and had to be told to stay in bed. RN A stated that if she had a resident who was at risk for falls frequent checks would need to bed done on the resident. On 11/09/24 at 10:02 AM, Licensed Practical Nurse (LPN) B recalled previously caring for the resident #2, who was confused, required total assistance from staff for transfers, and was at risk for falls. LPN B stated the resident's family would transfer the resident themselves, and had been told several times that the facility utilized mechanical lifts for transfers of the residents. The LPN stated resident #2 was a resident that staff needed to know where the she was at all times, as the resident was confused and would try to get out of bed, thinking she had to go to work, or clean her closet. The LPN said staff had to frequently repeat instructions to the resident, she said the resident did not need one-on-one supervision, but needed, lots of redirection and reassurance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/09/24 at 1:50 PM, in a telephone interview, CNA F stated she worked on the 3:00 PM to 11:00 PM shift. She recalled that on 9/20/24 she came to work at 3:00 PM, and during report from the off going CNA, resident #2 was in the dining room, roaming around in her chair. The CNA stated she went on her break between 6:30 PM to 7:00 PM, and when she came back from her break, she heard that the resident had fallen. However, records showed the resident was found on the floor at 4:31 PM, and CNA F stated she had not transferred resident #2 to her bed and could not say who placed the resident back in her bed. The CNA could not say if the resident was observed by staff between the time the resident was taken to her room by the family member, and the time when the resident was found on the floor. She stated she heard the nurses saying that the resident's family member placed her in bed. CNA F verbalized that when family visited the resident, when they were leaving they would always put the resident in her bed, without telling staff, and without staff assistance. The resident's care plan for at risk for falls and fall related injury related to history of falls, impaired mobility, medication usage, and weakness was initiated on 7/31/24, with revision on 9/23/24. Interventions included, Educate/remind resident to request assistance prior to ambulation, an added intervention on 9/23/24 was, Educate family to leave patient in the common area after visiting, call staff to assist resident for safe transfer. The facility's policy Fall Prevention Program implemented 11/01/20 and reviewed/revised 10/18/22 directed that for High-Risk Protocols, the facility should Provide additional interventions as directed by the resident's assessment, including but not limited to .Increased frequency of rounds Family/caregiver or resident education.