STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105645	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Bartram Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 6209 Brooks Bartram Drive Jacksonville, FL 32258	

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility and resident records, resident and staff interviews, and a review of facility policies titled Abuse, Neglect and Exploitation, Fall and Injury Reduction Best Practice Guidelines, and Bathroom Safety Best Practice, the facility failed to ensure sufficient safeguards and supervision to protect residents' right to be free from neglect by failing to ensure rehabilitation department staff were aware of, and implemented, care plan interventions to prevent two residents (Residents #2 and #1) from unavoidable falls with major injury, out of a total of seven residents reviewed for falls. On 11/10/25, the facility neglected to ensure that Resident #2 was wearing her physician-ordered hinged knee brace, locked in extension, while bearing weight on her right leg during a therapy session with Certified Occupational Therapy Assistant (COTA) A. The resident stepped back on her unsupported leg and fell, resulting in a nondisplaced fracture of the proximal tibia/fibula (upper end of the lower leg bones under the knee), a tear of the body and posterior horn of the medial meniscus (fibrocartilage band that spans the inner knee joint), hemarthrosis (bleeding into the joint cavity), substantial pain, fear of using the right leg, and a delayed discharge home. Ten days later, on 11/20/25, Resident #1, with a known fall history and identified as a high fall risk, was left unattended on the toilet by Physical Therapy Assistant (PTA) B and fell. She struck her head and suffered a subarachnoid hemorrhage of the right posterior temporal lobe (a medical emergency characterized by bleeding between the brain and its protective membranes occurring in the rear side of the brain near the temple) requiring admission to an acute care hospital. PTA B failed to recognize posted fall risk signage and a requirement for stand-by supervision while toileting and did not inform the resident's nurse or certified nursing assistant (CNA) that she was in the bathroom alone before leaving to treat another resident. The facility failed to ensure sufficient supervision and implement interventions to keep Residents #1 and #2 safe. This had the potential to place all 14 residents who required orthotic devices (devices used to support, align or correct movable body parts) at the time of survey and all 75 residents on active therapy caseload, at risk for a negative outcome or injury.Immediate Jeopardy (IJ) at a scope and severity of J (Isolated) was identified at 1:47 PM on 12/8/25.On 11/20/25, Immediate Jeopardy began.On 12/10/25 at 3:00 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 12/10/25.The findings include:Cross reference F689 and F867.1. An interview was conducted with Resident #2 on 12/8/25 at 10:57 AM. She was in bed with a full-length brace on her right leg. A wheelchair and a walker were in the room. The plastic sleeve on the back of her wheelchair contained an orange passport that instructed TTWB (toe-touch weight bearing), RLE (right lower extremity), wheelchair, assistance with transfers, and a hinged brace locked in extension. Resident #2 said she had been in the facility approximately two months and was receiving both OT (occupational therapy) and PT (physical therapy). She had two hip replacement surgeries before admission. The day (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	review of Resident #2's passport (a tip sheet used by the facility as part of the care plan that provides easy access to information related to the resident's transfer status, ambulation support, bed mobility and guest care. They are housed in a plastic sleeve, color coded [blue for standard, and orange for fall in facility and fall risk] and affixed to the resident's wheelchair or walker for easy access and travel with the resident) found it was dated 11/3/25, seven days before the fall. It included instructions for Brace locked in extension, hip precautions, no hip extension, external rotation or abduction [moving the leg from midline away from the body], walking backwards or pivoting on the RLE (right lower extremity). Uses wheelchair and walker and needs minimal caregiver assistance with transfers. (Photographic evidence obtained)A review of Resident #2's OT and PT Precautions found neither included the instructions for the brace until 11/19/25 (nine days after her fall), when the revision Hinged brace on at all times except skin checks and bathing. Locked in extension during weight bearing and when not weight bearing was added. (Photographic evidence obtained) 2.A record review for Resident #1 revealed she was admitted to the facility on [DATE] with diagnoses including unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing, fall on same level from slipping, tripping and stumbling without subsequent striking against object, malignant neoplasm (a dangerous and potentially life-threatening cancerous tumor) of unspecified bronchus or lung, secondary neoplasm of brain, long term use of anticoagulants (blood thinners), history of TIAs (transient ischemic attack or mini-stroke), and unspecified severe protein calorie malnutrition. The MDS Discharge Return Anticipated assessment dated [DATE] revealed that Resident #1 had a BIMS score of 11/15, indicating moderately impaired cognition. She required partial/moderate staff assistance with toileting, bed mobility, and toilet transfers and was receiving physical therapy and occupational therapy.Resident #1 was care planned on 11/1/25 (revised 11/21/25) for her risk for falls and/or injury related to falls, related to medical conditions. Has a history of fall with family present on 11/17/25. Interventions to prevent falls included, but were not limited to, assessing footwear, observing for unsteadiness, clutter free environment and assessing her per facility policy. (Photographic evidence obtained)A Skilled Nursing admission Fall Risk Assessment, dated 11/3/25, established Resident #1 at risk for falls with a total score of 52.0 (High).A review of Resident #1's medical record revealed an active physician's order, dated 11/3/25, for Xarelto (blood thinner) 10 mg every evening for atrial fibrillation. She also had a Fall Risk Protocol, dated 11/3/25, for frequent rounding for safety checks. Keep bed in low position except when rendering care every shift, red rounding for safety awareness every shift (11/3/25), and toe touch weight bearing to the RLE (11/3/25). Physical Therapy 5 times weekly for 8 weeks was ordered on 11/4/25. An order dated 11/20/25 instructed staff to transfer Resident #1 to [hospital name] emergency room for further evaluation and treatment status post unwitnessed fall with head injury.A nursing progress note, dated 11/17/25 at 10:07 AM, revealed that Resident #1 and two of her family members were outside the facility attempting to transfer her into a car so the resident could be taken to a scheduled follow-up appointment. One family member came back into the facility to request transfer assistance into the car. When the staff arrived at the car, the resident was observed on the ground in a kneeling position. The resident stated she did not fall, she sat on the ground. Resident #1's family member stated she witnessed the resident lower herself to the ground. An Occupational Therapist was nearby and assisted Resident #1 up off the ground and back into the wheelchair. Resident #1 did not complain of any pain or distress and had no apparent injury. The staff suggested that the resident come back into the facility to be assessed by a nurse. The family declined and stated the resident was going to visit the orthopedic physician. ARNP Y was notified.On 11/20/25 at 12:21 PM, Licensed Practical Nurse (LPN) X noted that (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	therapist told her Resident #1 was left on the toilet; LPN X said, No. CNA V explained that he had not told her either. CNA V was asked if this resident had a passport at the time of the fall. She stated, Yes, it was light blue. She also confirmed there was red rounding signage on the resident's door at that time.PTA D was interviewed on 12/8/25 at 3:00 PM. He explained that the evaluating therapist created the residents' passports upon initial evaluation. The passport color was changed from blue (standard) to orange in cases involving falls. The passport was put in place immediately and was typically used by the CNAs; this was especially for the PRN (as needed), 2nd and 3rd shift CNAs, as they had little to no contact with the therapy team. For the first therapy day, the resident's chart was pulled up by the treating therapist or aide. It included a diagnosis, weight-bearing status, and functional status. Assistive devices including braces were noted, and if under a doctor's order would be listed as a precaution. He was not sure who transcribed physician's orders for braces into the medical record, but therapy staff saw those on the daily schedule. Braces and immobilizers usually came with the resident from the hospital and were sometimes noted on the passport. They should be but would also be listed under precautions and in the electronic medical record (EMR), which all therapy staff had access to. An interview was conducted with the Lead COTA (LC) on 12/8/25 at 3:25 PM. She explained that an evaluating therapist saw newly admitted residents the morning after admission. The results went into therapy under precautions. When the daily therapy schedule was printed, those precautions were printed on the schedule. When the resident walked in, staff had all of the precautions. Staff were expected to read that before they worked with the resident. Passport was a system meant for CNAs, nurses or other therapists like as-needed staff who had not worked with the resident. Or, if a call bell rang and you assisted a resident who you did not know, the information traveled with the resident. You can't say, I didn't know what to do with the person. It is right there. The evaluating therapist completes the passport at the time of the initial evaluation. The star and red covered paper on resident doors are for falls and red rounding. Staff initial every time they lay eyes on residents during red rounding. Everyone, with no exception, must have stand-by assistance with toileting. If a resident feels like they need that (private) space, the nurse must determine if the resident is safe to sit alone. So, if you are not safe, then taking you to the toilet and leaving you there alone is not safe to do. If a patient goes to an appointment post-surgery or post-injury, therapy sends a packet to the doctor. The packet asks for weight bearing status, braces or orthotic schedules, etc. The form comes back to the Unit Manager, is scanned into and shows up on the [EMR]. The information is forwarded to the Director of Rehab (DOR) and to all therapy leads. The lead then updates the information in the precautions. When asked about Residents #1 and #2, the LC recalled that Resident #1 went to the hospital after her second fall. She was frail with little appetite and had to be handled with kid gloves. She fell first with family in the parking lot, so they changed her passport from blue to orange to alert that a fall had occurred. Then she fell from her bathroom toilet. [PTA B] is not negligent. She had asked him to assist her onto the toilet. Instead of standing there, he left. He could have called or used the call bell. [Resident #1] went to the intensive care unit. Resident #2 was with [COTA A] when she lost her balance and fell. He was attempting a laundry task with her. Her passport had the leg brace on it; it was to be on all the time. [COTA A] did not read the passport. [Resident #2] sustained two small fractures and was non-weight bearing for two weeks. Sometimes passports go unnoticed, but therapy issues constant reminders to check them. It was about knowing the passport was there, not paying attention, and not realizing the brace wasn't on. The LC said her [NAME] was, When in doubt, don't do it! Better off being safe. During an interview with COTA A on 12/9/25 at 11:46 AM, he confirmed that the daily therapy schedule received each morning (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	had all resident information on it. He stated he could also see the resident's transfer status in the [EMR]. The passport information was supposed to be consistent. He said he worked with Resident #2 once before. The day of the event was supposed to be her last day of therapy. On the day of the fall, they were going over a simulated laundry activity. The basket that hooked onto the top and side of her walker came loose. As he was fixing the basket, she stepped back onto her right leg, lost her balance and fell. She had her gait belt on, but he couldn't get to her fast enough. Prior to fall, she had good balance and was walking. The leg brace was not on the daily notes or the schedule and was not on the resident. Usually, the evaluating therapist put that information into the system. After the incident, within about a week, an all-staff meeting was held. They went over the incident and went over it one-on-one with the DOR. The DOR was interviewed on 12/9/25 at 12:03 PM. She stated the OT or PT initiated the passports which went in the sleeve on the back of the wheelchairs. Those contained basic information such as how a resident transferred and orthotic devices in use. The same information went in the therapy evaluation under precautions, which could also be seen in the EMR. When a therapist or assistant got a resident the first time, they got information regarding needed support and devices from the precautions or the initial evaluation. They could also review the passport. Resident #2 was with COTA A doing laundry and was scheduled to discharge the next day. The laundry simulator basket hook came loose and when COTA A went to move the basket, Resident #2 stepped back with her right leg, which she wasn't supposed to do due to her hip. She immediately complained of knee pain. X-rays were all negative, but that knee was swollen and painful. Then a mild tibial plateau fracture was discovered. She had gone to her orthopedic doctor on 10/31/25; he recommended she wear a brace, as her right knee was buckling, but there was a breakdown. The physician's order for the brace was supposed to be scanned into email for the DOR. Unfortunately, that precaution didn't show up on the daily schedule like it was supposed to. As for Resident #1, she had a prior fall while with family on 11/17/25. The day of the most recent fall, PTA B went to get Resident #1 for therapy, but she said she needed to go to the bathroom first. PTA B transferred her to the toilet and stepped into the hall to find a CNA, but the nurse couldn't find the CNA. He laid the call light across Resident #1's lap, asked her to use the call light and not get up, and left. Unfortunately, she fell. Reports are that the call light went on immediately. The nurse saw the PTA exit the room and described his behavior as kind of frantic; he was rushing like he had too many places to go. Resident #1 sus

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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 a review of facility and resident records, resident and staff interviews, and a review of the facility policy titled Fall and Injury Reduction Best Practice Guidelines and the Bathroom Safety Best Practice guidelines, the facility failed to ensure residents received adequate supervision and assistive devices to prevent unavoidable falls for two (Residents #2 and #1) of seven residents reviewed for falls.On 11/10/25 when Resident #2 was not wearing her physician-ordered hinged knee brace, she attended a therapy session with Certified Occupational Therapy Assistant (COTA) A. During the session she stepped back on her unsupported leg and fell, resulting in a nondisplaced fracture of the proximal tibia/fibula (upper end of the lower leg bones under the knee), a tear of the body and posterior horn of the medial meniscus (fibrocartilage band that spans the inner knee joint), hemarthrosis (bleeding into the joint cavity), substantial pain, fear of using the right leg, and a delayed discharge home. Ten days later, on 11/20/25, Resident #1, with a known fall history and identified as a high fall risk, was left unattended on the toilet by Physical Therapy Assistant (PTA) B and fell. She struck her head and suffered a subarachnoid hemorrhage of the right posterior temporal lobe (a medical emergency characterized by bleeding between the brain and its protective membranes occurring in the rear side of the brain near the temple) requiring admission to an acute care hospital. PTA B failed to recognize posted fall risk signage and a requirement for stand-by supervision while toileting and did not inform Resident #1's nurse or certified nursing assistant (CNA) that she was in the bathroom alone before leaving to treat another resident. Failure to ensure therapy orders were current and therapy staff were aware of care plan safety interventions had the potential to place all 14 residents who required orthotic devices (devices used to support, align or correct movable body parts) and all 75 residents on active therapy caseload at risk for injury.Immediate Jeopardy (IJ) at a scope and severity of J (Isolated) was identified at 1:47 PM on 12/8/25.On 11/20/25, Immediate Jeopardy began.On 12/10/25 at 3:00 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 12/10/25.The findings include:Cross reference F600 and F867.1. An interview was conducted with Resident #2 on 12/8/25 at 10:57 AM. She was in bed with a full-length brace on her right leg. A wheelchair and a walker were in the room. The plastic sleeve on the back of her wheelchair contained an orange passport that instructed TTWB (toe-touch weight bearing), RLE (right lower extremity), wheelchair, assistance with transfers, and a hinged brace locked in extension. Resident #2 said she had been in the facility approximately two months and was receiving both OT (occupational therapy) and PT (physical therapy). She had two hip replacement surgeries before admission. The day before she was supposed to get out of here, she was doing laundry with the OT aide. It got out of hand. She said she fell and broke her knee. The basket on her walker tipped as she was putting laundry in it and the walker fell over. She stepped back to get out of the way but there was nothing to hold on to, so she fell straight backwards. This caused a fracture in her shin bone and great pain in the knee. She was walking perfectly up to that point and did not have an order for a brace. She now has a brace on the knee. She did not wear a brace before the fall. The accident set her discharge back a month. She was walking some in therapy again but being super cautious as she did not want to fall again. She wasn't pushing it. When asked about the clear pouch on her wheelchair, Resident #2 confirmed it included doctor's orders, what she should and shouldn't do and the brace instructions.A review of a facility report authored by the Risk Manager (RM) on 11/21/25 revealed that on 11/10/25 at 2:00 PM, the therapy department notified the Unit Manager (UM) that Resident #2 had fallen while practicing a laundry task. According to COTA A, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	computer for diagnostic testing) of her head. Hospital records further revealed the CT revealed a subarachnoid hemorrhage in the right posterior temporal lobe of the brain.A review of facility training records found that on 11/18/25, eight days after Resident #2's fall and 2 days before Resident #1's fall, an all-staff meeting was conducted to discuss braces, splints, immobilizers, slings, boots and falls. PTA B was not in attendance. Training was conducted from 11/20/25 through 11/22/25 on the facility's safety protocol and bathroom safety best practice (stating NEVER leave high fall risk residents unattended on the toilet). PTA B was not in attendance. Training was conducted for the Rehabilitation Department on 11/24/25 on high fall risk residents. Twenty Rehab staff were in attendance, but PTA B was not there. (Photographic evidence obtained) LPN G was interviewed on 12/8/25 at 10:40 AM. She explained that the sleeved information on residents' wheelchairs included details about transfer status, mobility aides and orthotic devices. The therapy department updated the information as needed. If she found a discrepancy, she would check the physician's orders, report to the UM and request a correction. She would then notify the certified nursing assistants (CNAs). Most residents with orthotic devices came from the hospital with them; otherwise, nursing reported new orders to therapy to enter the order into the electronic record and for fitting. The therapy department's electronic recordkeeping system was connected to the electronic medical records system, so therapy staff had access to all residents' care plan interventions. It is a nice system.On 12/08/25 at 10:48 AM, an interview was conducted with CNA W. She was asked how she knew residents' plans of care, including any precautions required. She stated she could look at their doors because the facility used multiple different signs that meant different things, or she could look in the electronic medical record. She could also go to the wall where [RN I's] office was; everyone's folder was there. Lifting or ambulation status could be found on the resident's passport hanging on the wheelchair. She knew which residents were at high risk of falling because there would be a Target red rounding sheet of red paper on the door where staff could initial that they laid eyes on the resident every hour. A red star by the door meant the resident had fallen and they were now a high fall risk. She also made sure call lights were within the residents' reach. CNA W explained that the facility's process for toileting a resident who was a fall risk was, If they are a fall risk you can't leave them, you must be in the restroom with them at all times.On 12/08/2025 at 11:07 AM, an interview was conducted with RN U. She said the facility had a falling star system in place. Also, nurses could check to see what medications residents received that would put them at risk for falls. They could also refer to the hospital AHCA form 3008 (a medical certification for long term care) that notes fall risk and weight-bearing status, and how much assistance the residents needed for transfers and care. During the initial nursing assessment, each resident's status was assessed. When asked why she might review a resident's care plan, she stated, To know how to take care of them, how to talk to them, what kind of care you need to provide. When asked what resources the facility had to access resident restrictions or needed devices, she answered the POC (point of care) for the CNAs is one way; there they can see any changes in resident needs. Also, the red paper on the door means the resident should be checked every hour by any staff member. Red rounding; that means fall risk. There is also a passport that hangs on the back of the resident's wheelchair with information about fall precautions, any assistive devices and other safety measures. She concluded by explaining the facility's policy for toileting a resident who required assistance was to make sure to use a gait belt, and you are not supposed to leave them; you must always stay with them.In an interview with LPN X on 12/09/25 at 12:19 PM, she was asked to explain her understanding of the resident passport. She said when a resident was receiving rehab, therapy staff updated it to let staff know what limitations and restrictions existed. Staff might (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	expect to see how the resident transferred, whether they required a mechanical lift, what assistive devices they used and their weight-bearing status. Therapy updated the passports with changes. Her role in preventing falls included red rounding, which you see on the door, and frequent rounding. When a resident needed assistance with toileting, staff checked the passport to make sure they were not a two-person assist. Staff transferred residents by whichever means was appropriate; let them have their privacy by standing outside the door by the bathroom, and made sure they had their light to pull when they were finished. We leave nobody on the toilet alone. She was asked if she recalled a fall incident that occurred on 11/20/25 with Resident #1. She stated, Yes. She recalled standing in the hallway at her cart when she saw a therapist standing in the hallway looking around, like he was trying to decide what to do. The call light was going off in the room where he was standing. At that time the therapist left, and the CNA was coming around the corner. The CNA asked LPN X, Who put this lady on the toilet? The CNA went back into the room and by the time LPN X reached the room, the CNA was with the resident in the bathroom; the resident was on the floor. On 12/09/25 at 2:40 PM an interview was conducted with CNA V. She knew what level of care the residents needed, including any precautions or restrictions they had, from shift report, talking to the nurse, the electronic plan of care and the resident folders behind the nursing desk. She knew which residents were at risk for falls because they had a wrist band, neighborhood watch (eyes) on the door, or they had a star on their door. They got that information in report also. The facility process for toileting a resident who was a fall risk was to supervise them going to the toilet. She left their bathroom door open but closed the door to the room so she could see them and give them privacy. We never leave a person on the toilet by themselves; they must always be in reach. CNA W recalled a fall incident that occurred with Resident #1 on 11/20/25. She stated she was not working with her that day; she was working in room [ROOM NUMBER]. She came around the corner and saw her call light was on. She walked over to her room and saw LPN X down the hall. When she asked the nurse who put Resident #1 on the toilet, LPN X said therapy was in the room with her. When CNA V went in, there was no one there. CNA V then saw Resident #1 on the floor in the bathroom. She went to the door and yelled for the nurse to come because the resident was on the floor. She asked LPN X if the therapist told her Resident #1 was left on the toilet; LPN X said, No. CNA V explained that he had not told her either. CNA V was asked if this resident had a passport at the time of the fall. She stated, Yes, it was light blue. She also confirmed there was red rounding signage on the resident's door at that time.PTA D was interviewed on 12/8/25 at 3:00 PM. He explained that the evaluating therapist created the residents' passports upon initial evaluation. The passport color was changed from blue (standard) to orange in cases involving falls. The passport was put in place immediately and was typically used by the CNAs; this was especially for the PRN (as needed), 2nd and 3rd shift CNAs, as they had little to no contact with the therapy team. For the first therapy day, the resident's chart was pulled up by the treating therapist or aide. It included a diagnosis, weight-bearing status, and functional status. Assistive devices including braces were noted, and if under a doctor's order would be listed as a precaution. He was not sure who transcribed physician's orders for braces into the medical record, but therapy staff saw those on the daily schedule. Braces and immobilizers usually came with the resident from the hospital and were sometimes noted on the passport. They should be but would also be listed under precautions and in the electronic medical record (EMR), which all therapy staff had access to. An interview was conducted with the Lead COTA (LC) on 12/8/25 at 3:25 PM. She explained that an evaluating therapist saw newly admitted residents the morning after admission. The results went into therapy under precautions. When the daily therapy schedule was printed, those precautions were printed on the schedule. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bartram Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 6209 Brooks Bartram Drive Jacksonville, FL 32258	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When the resident walked in, staff had all of the precautions. Staff were expected to read that before they worked with the resident. Passport was a system meant for CNAs, nurses or other therapists like as-needed staff who had not worked with the resident. Or, if a call bell rang and you assisted a resident who you did not know, the information traveled with the resident. You can't say, I didn't know what to do with the person. It is right there. The evaluating therapist completes the passport at the time of the initial evaluation. The star and red covered paper on resident doors are for falls and red rounding. Staff initial every time they lay eyes on residents during red rounding. Everyone, with no exception, must have stand-by assistance with toileting. If a resident feels like they need that (private) space, the nurse must determine if the resident is safe to sit alone. So, if you are not safe, then taking you to the toilet and leaving you there alone is not safe to do. If a patient goes to an appointment post-surgery or post-injury, therapy sends a packet to the doctor. The packet asks for weight bearing status, braces or orthotic schedules, etc. The form comes back to the Unit Manager, is scanned into and shows up on the [EMR]. The information is forwarded to the Director of Rehab (DOR) and to all therapy leads. The lead then updates the information in the precautions. When asked about Residents #1 and #2, the LC recalled that Resident #1 went to the hospital after her second fall. She was frail with little appetite and had to be handled with kid gloves. She fell first with family in the parking lot, so they changed her passport from blue to orange to alert that a fall had occurred. Then she fell from her bathroom toilet. [PTA B] is not negligent. She had asked him to assist her onto the toilet. Instead of standing there, he left. He could have called or used the call bell. [Resident #1] went to the intensive care unit. Resident #2 was with [COTA A] when she lost her balance and fell. He was attempting a laundry task with her. Her passport had the leg brace on it; it was to be on all the time. [COTA A] did not read the passport. [Resident #2] sustained two small fractures and was non-weight bearing for two weeks. Sometimes passports go unnoticed, but therapy issues constant reminders to check them. It was about knowing the passport was there, not paying attention, and not realizing the brace wasn't on. The LC said her [NAME] was, When in doubt, don't do it! Better off being safe.During an interview with COTA A on 12/9/25 at 11:46 AM, he confirmed that the daily therapy schedule received each morning had all resident information on it. He stated he could also see the resident's transfer status in the [EMR]. The passport information was supposed to be consistent. He said he worked with Resident #2 once before. The day of the event was supposed to be her last day of therapy. On the day of the fall, they were going over a simulated laundry activity. The basket that hooked onto the top and side of her walker came loose. As he was fixing the basket, she stepped back onto her right leg, lost her balance and fell. She had her gait belt on, but he couldn't get to her fast enough. Prior to fall, she had good balance and was walking. The leg brace was not on the daily notes or the schedule and was not on the resident. Usually, the evaluating therapist put that information into the system. After the incident, within about a week, an all-staff meeting was held. They went over the incident and went over it one-on-one with the DOR. The DOR was interviewed on 12/9/25 at 12:03 PM. She stated the OT or PT initiated the passports which went in the sleeve on the back of the wheelchairs. Those contained basic information such as how a resident transferred and orthotic devices in use. The same information went in the therapy evaluation under precautions, which could also be seen in the EMR. When a therapist or assistant got a resident the first time, they got information regarding needed support and devices from the precautions or the initial evaluation. They could also review the passport. Resident #2 was with COTA A doing laundry and was scheduled to discharge the next day. The laundry simulator basket hook came loose and when COTA A went to move the basket, Resident #2 stepped back with her right leg, which she wasn't (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	supposed to do due to her hip. She immediately complained of knee pain. X-rays were all negative, but that knee was swollen and painful. Then a mild tibial plateau fracture was discovered. She had gone to her orthopedic doctor on 10/31/25; he recommended she wear a brace, as her right knee was buckling, but there was a breakdown. The physician's order for the brace was supposed to be scanned into email for the DOR. Unfortunately, that precaution didn't show up on the daily schedule like it was supposed to. As for Resident #1, she had a prior fall while with family on 11/17/25. The day of the most recent fall, PTA B went to get Resident #1 for therapy, but she said she needed to go to the bathroom first. PTA B transferred her to the toilet and stepped into the hall to find a CNA, but the nurse couldn't find the CNA. He laid the call light across Resident #1's lap, asked her to use the call light and not get up, and left. Unfortunately, she fell. Reports are that the call light went on immediately. The nurse saw the PTA exit the room and described his behavior as kind of frantic; he was rushing like he had too many places to go. Resident #1 sustained a hematoma and a small subarachnoid hemorrhage, was transferred out, and did not return.A review of the facility's policy titled Fall and Injury Reduction Best Practice Guidelines (BC ADMIN-035 Effective/Last Reviewed/Updated 05/2025), revealed:The policies and procedures are intended to promote fall and injury reduction activities during the daily care of residents. All newly admitted residents are to be considered a fall risk until evaluated. Guest passports are to be used as a means of communication regarding resident transfer status. For toileting, all residents with a STOP sign in their room require staff to remain at arm's length/line of sight inside the bathroom. Do not leave high risk residents unattended on the toilet. Assist the resident back to bed before you leave. (Photographic evidence obtained)A review of the facility's Bathroom Safety Best Practice guidelines instructed staff to never leave high

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of the facility's policy titled QAPI (Quality Assurance and Performance Improvement) Plan, facility and resident records and staff interviews, the facility failed to have an effective QAPI process that utilized adverse incident data to identify root cause analyses (RCAs), develop effective performance improvement activities to prevent recurrence of an avoidable injury after one (Resident #2) of seven residents reviewed for falls fell in the presence of Certified Occupational Therapy Assistant (COTA) A while not wearing a physician's ordered leg brace during a therapy session. She suffered a nondisplaced fracture of the proximal tibia/fibula (upper end of the lower leg bones under the knee), a tear of the body and posterior horn of the medial meniscus (fibrocartilage band that spans the inner knee joint), hemarthrosis (bleeding into the joint cavity), substantial pain, fear of using the right leg. The QAPI committee was not involved in identifying a root cause of the incident or developing a timely and effective performance improvement plan (PIP) or corrective action plan to prevent future similar occurrences. As a result, ten days later (11/20/25), Resident #1, with a known fall history and identified as a high fall risk, was left unattended on the toilet by Physical Therapy Assistant (PTA) B and fell. She struck her head and suffered a subarachnoid hemorrhage of the right posterior temporal lobe (a medical emergency characterized by bleeding between the brain and its protective membranes occurring in the rear side of the brain near the temple) requiring admission to an acute care hospital. The failure to develop measures needed to ensure the safety and protection of other residents had the potential to affect all 97 residents should an injury incident occur. Immediate Jeopardy (IJ) at a scope and severity of L (widespread) was identified at 1:47 PM on 12/8/25.On 11/20/25, Immediate Jeopardy began.On 12/10/25 at 3:00 PM, the Administrator was notified of the IJ determination. IJ templates were provided, and Immediate Jeopardy was ongoing as of the survey exit on 12/10/25.The findings include:Cross reference F600 and F689.1.A review of the facility's policy titled QAPI (Quality Assurance and Performance Improvement) Plan (BC ADMIN-058 effective 05/2017 last reviewed/updated 05/2025), revealed:The scope of the QAPI program encompasses all segments of care and services provided by [facility's name] that impact clinical care, quality of life, resident choice and care transitions with participation from all departments. The purpose of the plan includes a proactive approach for caring, and states that to achieve this, all employees will participate in ongoing QAPI efforts. Feedback, data systems and monitoring include tracking, investigating and monitoring adverse events every time they occur, and action plans implemented through the plan. The QAPI team will review sources of information to determine if gaps or patterns in the system of care that could result in quality problems; or if there are opportunities to make improvements. Based on the result of the review of the information, the QAPI team will prioritize opportunities for improvement, taking into consideration the importance of the issues (high risk, high frequency, and/or problem prone). The QAPI team will determine which problems will become the focus for a performance improvement project (PIP). The PIP Team is entrusted with a mission to look into a problem area and come up with plans for correction and/or improvement. The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes and implications for change. The approach comprehensively assesses all involved systems to prevent future events and promote sustained improvement. (Photographic evidence obtained)A review of a facility report authored by the Risk Manager (RM) on 11/21/25 revealed that on 11/10/25 at 2:00 PM, the therapy department notified the Unit Manager (UM) that Resident #2 had fallen while practicing a laundry task with COTA A. She was filling a basket attached to her walker with laundry. The basket started (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	to fall. When COTA A attempted to adjust it, Resident #2 lost her balance and fell to the floor. Resident #2 complained of right knee pain and sustained a right forearm skin tear. An MRI (Magnetic Resonance Imaging - a non-invasive medical test that uses strong magnets, radio waves, and a computer to create detailed pictures of your body's organs, tissues, and skeletal system) on 11/11/25, revealed a nondisplaced fracture of the proximal tibia and fibula (upper end of the lower leg bones under the knee), tear of the body and posterior horn of the medial meniscus (fibrocartilage band that spans the inner knee joint), moderate hemarthrosis (bleeding into the joint cavity), and mild subcutaneous edema (swelling) around the knee. The facility investigation concluded that Resident #2 was not wearing her physician-ordered hinge brace locked in extension at the time of the accident.A review of a second facility report authored by the RM on 11/21/25 revealed that on 11/20/25, ten days after Resident #2's accident, Certified Nursing Assistant (CNA) V answered a call light for room [ROOM NUMBER]. CNA V discovered Resident #1 on the bathroom floor. Advanced Registered Nurse Practitioner (ARNP) Y evaluated the resident and observed a hematoma (bruise) to her left scalp and abrasion and hematoma to the left ear. She was sent to the Emergency Room. The facility's initial investigation revealed that PTA B had placed Resident #1 on the toilet, placed her call light across her lap and told her to pull it when she was finished. He left the room but did not see a nurse or CNA to tell them that Resident #1 was on the toilet. The PTA did not see the sign on the door indicating that Resident #1 was a fall risk. A computed tomography (CT) scan at the hospital revealed development of trace subarachnoid hemorrhage in the right posterior temporal lobe sulci (a medical emergency characterized by bleeding between the brain and its protective membranes) and she was admitted to the hospital. A facility tour on 12/8/25 at 10:15 AM revealed a system using door symbols, such as red stars and blue water droplets and red construction paper taped to the door concealing white paper underneath. The white paper had time slots for staff initials when they visited the room. Residents were observed throughout the facility using wheelchairs and walkers with plastic sleeves containing orange or blue pieces of construction paper.A medical record review for Resident #2 found she was admitted on [DATE]. Her admitting diagnosis was aftercare following joint replacement surgery. Resident #2 required assistance with activities of daily living (ADLs) and supervision or touch assistance for transfers. Additional diagnoses included but were not limited to osteoporosis (bone disease making the bones weak and brittle), muscle weakness, presence of a right artificial hip joint and unsteadiness on feet. Active discharge planning was occurring for her to return to the community. Resident #2 was care-planned on 10/17/25 for discharge with a goal of returning home, walking safely and being independent. She was care-planned for the risk of complications associated with decreased ADL self-performance related to decreased mobility and weakness. The goal was to maintain self-performance levels as evidenced by no decline through the next review date. Interventions included ambulation and transfer support as needed. The care plan also referred to a passport tip sheet that contained information relevant to the resident's needs. On 10/31/25, Resident #2 saw her orthopedic physician for a follow-up appointment. He noted weight bearing status for her right lower extremity (RLE) was weight bearing as tolerated (WBAT) with a walker and with a hinged knee brace locked in extension with all weight bearing. On 10/31/25 ARNP E ordered the recommended brace in the electronic record. A review of Resident #2's OT (occupation therapy) and PT (physical therapy) Precautions found the brace was not added to either until 11/19/25 (nine days after her fall). (Photographic evidence obtained)Registered Nurse (RN) I authored a nursing progress note dated 11/10/25 revealing that Resident #2 fell while practicing a laundry activity resulting in an inability to manipulate her right knee. The Interdisciplinary Team (IDT) met on 11/11/25 to discuss Resident #2's fall. Notes reflected a discussion that (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #1 had a prior fall on 11/17/25. On the day of the most recent fall, PTA B transferred Resident #1v to the toilet and left, leaving her unsupervised. Unfortunately, she fell. Resident #1 sustained a hematoma and a small subarachnoid hemorrhage, was transferred out, and did not return.An interview was conducted with the Risk Manager on 12/9/25 at 3:30 PM. She said when an incident occurred where there was potential for injury, staff reported it to her. During morning meetings, if an incident contributed to a potential injury, a root cause analysis (RCA) meeting was held within 24 to 48 hours. The UM, DON, RM, Administrator, nurse and CNA involved, and any witnesses attended that meeting. This meeting was separate from QAPI meetings; the QAPI/QA (Quality Assurance) committee was not involved. If, during the investigation, she identified that corrective action was needed, they developed a corrective action plan (CAP) and started educating staff. This process was informal and could be done verbally or via email. After the incidents with Residents #2 and #1, they held an all-staff meeting and provided relevant education. After Resident #2's fall, a RCA was conducted and miscommunication about the brace was the concern. When asked about the QA committee's involvement in post-incident efforts, she said there was a QAPI meeting in November, but a performance improvement project (PIP) had not been developed yet, so it was not reviewed. Meetings were monthly and new PIPs would be reviewed at the next meeting (in December). The Medical Director and all key personnel attended the QA meetings. She continued explaining that Resident #1 fell on [DATE] and immediately went to the hospital where she was diagnosed with a hematoma. PTA B admitted to leaving Resident #1 in the bathroom with the call light in her lap. There was a star and red rounding sheet posted on her door, and PTA B should have known the policy that stand-by supervision was required for all fall risk residents. A risk meeting was conducted on 11/21/25 and an RCA was established. No PIP was developed in response. Instead, education on the fall policy was provided. Education was still ongoing and all staff would be trained at the meeting next week. When asked if the QA committee was involved or had reviewed this incident she said, no, but it would be involved next week. When asked how the facility utilized its QA committee, the RM explained that the committee reviewed PIPs after they were developed. The Medical Director was not involved in PIP development. The PIPs were presented to the QA committee at the next scheduled meeting. The committee really did not give input or recommend changes; they just provided a review of quality measures. An interview was conducted with the Administrator on 12/10/25 at 10:50 AM. He said he was the QAPI chairperson. Monthly meetings were conducted with all required members. Outside of those, the IDT conducted daily clinical meetings. They collaborated and figured out best actions to take when an issue arose such as whether an RCA or further investigation was needed. They then scheduled an RCA meeting and brought in the appropriate department to address areas of concern. He, the RM, DON, UM, therapy department, ADON (Assistant Director of Nursing), and CNAs involved attended the meetings. Once the RCA was done, the team worked on education as a first step and put together a PIP. This was not completed formally. Depending on the severity of the issue, they reviewed the concern, and reviewed RCA and PIP progress at the next QA meeting. The committee determined whether improvements had been made or if the PIP was it a toad, and if so, what changes were needed. The Administrator was advised of the purpose of the QA committee; that it was the entity responsible for conducting RCAs and developing PIPs in response to adverse incidents. He expressed understanding and said both incidents would be reviewed at the next meeting, on 12/16/25. When asked again, he confirmed the QA committee had not been involved with either incident. He explained that the Medical Director's availability was a barrier to ad hoc meetings and the team wanted to get a jump start on a plan. He acknowledged after Resident #2's fall and fracture, that facility efforts were unsuccessful as evidenced by a second unavoidable injury accident involving a therapy aide. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	When asked about the governing body's (GB) oversight of the QAPI process, the Administrator said at least one member of the GB attended each QAPI meeting via virtual meeting. Either the Chief Medical Officer, Chief Operating Officer, Chief Executive Officer, or the Chief Nursing Officer attend. When asked if the GB members were aware that the RCA and PIPs were being created without the involvement of the QA committee, he confirmed that they were, citing again that the facility wanted to jump right in immediately and not wait after an incident occurred.An interview was conducted with the Medical Director (MD) on 12/10/25 at 1:15 PM. He said he was notified immediately after each injury/incident occurred. The facility did an RCA and PIP. The MD said he met every morning with nurse managers, care managers and the DOR to discuss residents and issues. A smaller group later met to discuss incidents and determine how they could have happened. The MD confirmed he was a QA committee member and participated in monthly and post-incident QAPI activities. The QAPI process requirements were shared with him. Acknowledging the QAPI process was not being followed as intended, the MD suggested this Agency representative share recommendations with the facility, give them time to correct, then conduct a revisit.