STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105714	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concordia Manor	321 13th Ave N Saint Petersburg, FL 33701

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to honor a resident's shower preferences for one resident (#4) of one sampled.Findings included: On 8/24/2025 at 10:00 a.m., an observation of Residents #4 revealed she was sitting in her bed. She expressed concerns related to her showers. Resident #4 stated she's been telling staff that she needs to have regular shower so she could feel like a normal person. Resident #4 said she gets bed baths, and they can't shower her. The resident did not know why the staff could not shower her.Review of Resident #4's progress note dated 8/15/2025 at 6:07 a.m. revealed . resident also stated she wants a shower due to not being offered one. states[sic] isn't she supposed to have a shower weekly. resident[sic] education on tuesday[sic] and friday[sic] schedule.A review of Residents #4 Admissions Record revealed an admission date of 5/23/2025 with diagnoses to include: multiple sclerosis, morbid (severe) obesity, type 2 diabetes, muscle wasting and atrophy, muscle weakness, urinary tract infection, absence of right leg above the knee and absence of left leg above the knee.A review of Residents #4's Initial Minimum Data Set (MDS), dated [DATE], revealed Section C- Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating Resident #4 is cognitively intact. Section GG- Functional Abilities showed the resident is dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity.) for tub/shower transfers.A review of Resident #4's Care Plan Report revealed a activities of daily living (ADL) care plan with a revision date of 6/1/25. The focus revealed [Resident #4] has an ADL Self Care Performance Deficit r.t [related to] multiple comorbidities, Bil AKA [bilateral above the knee amputation], impaired mobility, activity intolerance. The goal revealed Will improve level of self performance by next review. The interventions included BATHING: The resident requires Assist of 1. Review of Resident #4's care plan with a revision date of 6/1/25 revealed a focus of [Resident #4] has an Amputation of Bilateral AKA. The goal revealed Maintain ADL status. The interventions included Monitor/document emotional status of resident. Observed resident acceptance of body image changes, ability to cope with physical changes. Be supportive. Encourage resident to vent fears, concerns and any other relevant feelings.Review of a Kardex (a document identifying residents specific care needs) dated 8/24/2025 showed Resident #4 required assistance of one staff member for bathing and her scheduled shower day is every Tuesday and Friday to be given during the 7:00 a.m. to 3:00 p.m. shift.On 8/24/2025 at 11:00 a.m. an interview was conducted with Staff A, Certified Nursing Assistant (CNA). She said she's worked with Resident #4 for the past five months. Staff A, CNA confirmed she is aware the resident preferred a shower but said it was impossible to honor Resident #4's wishes due to not having a shower chair big enough for the resident. Staff A, CNA stated the facility did not have bariatric supplies such as a bariatric shower chair. Staff A, CNA said, No we don't have those. An observation of the shower room was conducted with Staff A, CNA at the time of the interview. There was no bariatric shower equipment observed, and Staff A, CNA confirmed all the shower chairs were the same size and they did not have anything to accommodate a bariatric patient who would want a shower. On 8/24/2025 at 1:00 p.m. an interview was conducted with Staff B, Physical Therapy Assistant (PTA). She confirmed that she had previously been working with Resident #4 in physical therapy and was working on a sliding board for transfers. Staff B, PTA stated she had not been asked about bariatric sizes for the residents' chairs or shower chairs or wheelchairs, but if it was brought to her attention, she would inform the administration team and would expect them to order it.On 8/24/2025 at 2:16 p.m. an interview was conducted with Staff C, Regional Consultant. Staff C, Regional Consultant confirmed she was unaware and pretty sure they did not have bariatric size shower chairs for patients to utilize. Review of Resident #4's shower documentation revealed Resident #4 only had a bed bath on 8/19/25 and the resident had not received a shower since admission on [DATE].On 08/24/2025 at 3:00 p.m. an interview was conducted with Staff D, Regional Nurse Consultant (RNC). Staff D, RNC stated they did not have any policy or procedure that included reasonable accommodation of needs/preferences for bariatric equipment.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 observation, interviews, and record review, the facility failed to protect the residents' right to be free from neglect related to ensuring safety during bed mobility consistent with the assessed and care planned needs for three residents (#2, #5, and #6) of three residents sampled for abuse and neglect.Resident #2 sustained a fall from the bed during care, resulting in a transfer to a higher level of care due to acute pain and was diagnosed with a hip fracture. Resident #2, a vulnerable resident, was not promptly assessed post fall, and the resident's acute pain was not addressed in a timely manner. The facility failed to ensure Resident #2 was seen by a physician and that an ordered X-ray was completed. Resident #2, who was contracted and had other comorbidities, was not a candidate for surgical intervention resulting in on-going physical and psychosocial pain.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury or death to Residents #2 and resulted in the determination of Immediate Jeopardy on 9/10/25. The findings of Immediate Jeopardy were determined to be removed on 9/10/25 and the scope and severity was reduced to an E.Findings included: 1. On 08/24/2025 at 1:30 p.m. Resident #2 was observed in bed. The resident spoke very faintly and was able to nod to yes and no to questions. The resident said she had been in constant pain since the fall. The resident stated, “I have pain in my hip, a lot, medications are helping sometimes and sometimes I do not receive it [pain medication]”. The resident stated on the day of the fall, 08/03/2025, there was one staff member in the room providing care. Resident #2 stated, “[the staff member] was changing me. I was cold and needed my cover. I don't know what happened I just fell to the ground.” The resident said when the fall occurred that staff member yelled out to get help then two more staff members came and assisted the resident back to bed. The resident stated she did not get out of bed and reported feeling worse since the fall. Resident #2 reported being in pain and not being able to eat at the time of the interview. On 09/08/2025 at 1:00 p.m. an observation and interview were conducted with Resident #2. Resident #2's Power of Attorney (POA) and a family member were observed at the bedside brushing the resident's hair. The resident stated being okay, but was still in pain, Resident #2 said, “When they move me, it hurts. ” The resident said the nurse administered pain medication sometimes. Review of Resident #2's “admission Record” revealed Resident #2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur, initial encounter for closed fracture, onset date 08/06/2025. Other diagnoses included contracture of right shoulder, contracture unspecified joint, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unilateral osteoarthritis of right hip and left hip, muscle wasting and atrophy of right and left lower leg. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/25 at 5:33 p.m. a telephone interview was conducted with Staff G, Certified Nursing Assistant (CNA). Staff G, CNA confirmed they were assigned to Resident #2 on 08/03/2025 and went to their room around 7:30 p.m. to provide care. Staff G, CNA reported standing by Resident #2's bedside, caring for her, and had just pulled down the covers when the resident began pointing at the sheet and stated she was cold. Staff G, CNA said she was going to change the resident when the resident began shivering and shaking. Staff G, CNA stated, “I turned around to get the sheet and I said let me cover you. When I went to get the sheet and turned around, [Resident #2] was on the floor. I yelled out for help.” Staff G, CNA confirmed they were the only staff member in the room at the time of the fall and said there were no other CNAs on that hall. Staff G, CNA said two nurses came to the room and assessed Resident #2 and helped get the resident back in bed. Staff G, CNA stated she had provided care to Resident #2 prior to the incident with no other staff assisting, including bathing and changing, but only found out after the fall that the resident required two staff assistance. Staff G, CNA did not know if there was enough staff at the facility at the time of the fall. Staff G, CNA said the facility had agency nurses working that shift and there had originally been two CNAs on the back hall but, one of them may have left around 7:30 p.m. but Staff G, CNA didn't remember exactly and didn't know why they left. Staff G, CNA confirmed she did not ask for assistance to provide care to Resident #2 on 08/03/2025 due to everyone being busy. Staff G, CNA also stated she had only worked in the facility a few times prior to this incident and had not had any training on the care of Resident #2. On 09/08/2025 at 1:00 p.m. an interview was conducted with Resident #2's family member and their POA while they visited Resident #2. The family member and POA both restated their concerns. They stated on the day of the fall, the resident was being turned during care, there was only one staff member present, and the staff dropped the resident. The family stated Resident #2 was bedridden and when the resident fell on [DATE] the staff put the resident back in bed instead of getting the resident help. They reported there was no phone call made to the family about the resident's fall and the POA found out from another family member the resident was in the hospital. The family member and the POA stated when they went to the hospital, they had a hard time finding the resident due to Resident #2 being admitted with the wrong name. The family stated Resident #2 reported a lot of pain once they arrived. The family member said, “I asked what happened. [Resident #2] said they dropped me. I asked, Who dropped you? [Resident #2] said, the people at the nursing home. [Resident #2] said it was a lady, wearing a red weave [hair]. She was turning me. [Resident #2] said pointing on their hip, it hurts.” The family said Resident #2 explained that two men had assisted Resident #2 back to bed. The resident's family member stated they spoke with the attending physician at the hospital, and it was explained to them that the hospital tried to do surgery but had to rule it out due to the resident being contracted. The family stated Resident #2 was discharged back to the facility and they visited the following morning around 11:00 a.m. only to find Resident #2 crying, in pain, and had not had any pain medication. The family member said they spoke with the nurse and two CNAs who were sitting at the nurses' station and asked when Resident #2 had pain medication last. The nurse said they did not have pain medication for Resident #2 because the prescription came with the wrong name, and they had to resubmit the prescription. The family member said the nurse reported the last dose of pain medication Resident #2 had was at the hospital, the night before. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's care plan, revised on 11/02/2023 revealed “[Resident #2] has an ADL [activities of daily living] Self-Care Performance Deficit r/t [related to] impaired mobility due to CVA [cerebrovascular accident] with right sided hemiparesis.” The goal revealed “Will maintain current level of self performance with ADLs through next review.” The interventions included “BED MOBILITY: Dependent of 2 to turn and/or reposition Revision on: 01/09/2024. TRANSFER: TOTAL Mechanical lift to Chair of 2, Sling M [medium]. PERSONAL HYGIENE: dependent, initiated on 01/09/2024. DRESSING: Totally Dependent on staff for dressing. Date Initiated: 01/09/2024. TOILET USE: Dependent, Revision on: 01/09/2024.” Review of Resident #2's Fall care plan revised on 11/02/2023 revealed “[Resident #2] is at risk for falls or fall related injury because of: impaired mobility r/t Dx [diagnoses] Cva[sic] with Right hemiplegia, decreased safety awareness, and medication use.” The goal revealed “Will minimize the risk of falls through review date.” The interventions included “perimeter mattress, Date Initiated, 08/21/2025. Report falls to physician and responsible party, date Initiated, 05/04/2020. Provide environmental adaptations: Call light within reach, Date Initiated, 05/04/2020. Anticipate and meet the resident's needs, date initiated, 05/04/2020. Provide environmental adaptations: Adequate lighting, Date Initiated, 05/04/2020. Provide environmental adaptations: Area free of clutter, Date Initiated, 05/04/2020.” This review showed the new intervention was implemented 18 days after Resident #2's fall. Resident #2 had a care plan initiated on 08/10/25 that revealed “Resident #2 has a right femur Fracture.” The goal “Will remain free of complications related to hip fracture, such as contracture formation, embolism and immobility through review date.” The interventions revealed “Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Follow MD [Medical Doctor] orders for weight bearing status. See MD orders and/or PT [physical therapy] treatment plan. Modify environment as needed to meet current needs: non-slip surface for bath/shower, Bed in lowest position with wheels locked, Floors that are even and free from spills, clutter, Adequate, glare-free light. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. Observe limb for swelling and skin changes. Take pedal pulses as indicated. PT, OT [occupational therapy] evaluation and treatment per orders. Reposition as necessary to prevent skin breakdown. Prevent 90 degree flexion to prevent circulation problems.” Review of Resident #2's progress note dated 08/03/2025 at 8:38 p.m. revealed, “Resident is post fall 20:15 [8:15 p.m.]. Per CNA, resident was being changed, and [Resident #2] rolled out of the bed. Resident denies hitting her head. Denies any pain or discomfort. No injury or bruising noted. Two person assist with transfer to bed. Call placed to [family member], at 10:25 p.m. Left message to call when available. Call placed to on-call for PCP [Primary Care Physician]. Awaiting return call. Resident is resting in bed watching TV [television]. No signs of acute distress or discomfort. Respirations are even and unlabored on room air. Bed in lowest locked position. Call light and side table within reach. Increased rounding for safety by nursing staff.” Review of Resident #2's progress note dated 08/04/2025 at 10:50 a.m. revealed, “Patient reports left knee pain. PCP [primary care physician] made aware. Per PCP to order x-ray of left knee.” Review of the e-MAR (electronic Medication Administration Record) note dated 08/04/2025 at 11:02 a.m. revealed Resident #2 received Acetaminophen tablet 325 milligram (mg) for mild-moderate pain. “pt c/o [complained of] l [left] knee pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note for Resident #2 dated 08/05/2025 at 10:18 a.m. revealed “Resident with order for X-ray for pain. X-ray company unable to come promptly, order to send resident to ER [emergency room] for follow up.” Review of Resident #2's progress note dated 08/05/2025 at 11:44 a.m. revealed “Resident was transferred to the hospital.” Review of Resident #2's progress note, dated 08/05/2025 at 4:04 pm. Revealed “Nursing Assistant notified this transcriber that resident was crying due to right hip pain. Resident transferred to [Hospital] for further evaluation. MD notified.” Review of a progress note for Resident #2 dated 08/06/2025 at 1:22 a.m. revealed “called [Hospital]. at first and gave name of patient to see if she was admitted . [Hospital] stated they did not have her in their facility. resident[sic] put in their system with a different name. i[sic] called [Hospital A] and [Hospital B] and [Hospital C] to then call back [Hospital] to then use her birthday to ask again. her[sic] name was different in their system. resident[sic] was admitted with a right hip fracture on 8/5/25.” Review of Resident #2's hospital discharge summary for Resident #2 titled, “Final Report”, dated 08/05/2025 revealed “Chief Complaint ems [emergency medical services] from [Facility Name] unwitnessed fall from bed yesterday, left hip pain xray did not show up to facility, so sent here. deficits[sic] from prior stroke, dysphagia and right hemiplegia… History of Present Illness The patient is a [AGE] year-old, …who presents with left hip pain following a fall. The fall occurred yesterday at her nursing home and was unwitnessed; Staff found her on the floor complaining of left hip pain. An x-ray was ordered to be done at the facility, but the imaging team did not arrive. Due to ongoing pain and concern for fracture, she was sent to the emergency department for further evaluation. She is bedbound and severely contracted…A CT [Computed Tomography] of the pelvis was performed after plain films were abnormal but inconclusive, which confirmed an acute right hip fracture. …Chart Summary Patient is a poor surgical candidate. Patient is bedbound and contracted. No acute surgical intervention planned.” Review of the Hospital discharge medications list showed an order for Oxycodone 5 mg oral tablet, every 4 hours interval as needed for pain. Review of the hospital discharge instructions dated 08/06/2025 revealed “You Need to Schedule the Following Appointments” follow up with primary care provider, only if needed within 3-5 days, only if needed.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record for Resident #2 revealed there was no evidence of the physician seeing Resident #2 throughout the month of August 2025. On 08/24/2025 at 3:08 p.m. an interview was conducted with Staff D, Regional Nurse consultant (RNC), and the Nursing Home Administrator (NHA). The RNC stated the provider was notified of the resident's fall. The RNC confirmed there were no provider notes in the resident's record to confirm if the resident had been seen by a provider. Review of a progress note for Resident #2 dated 08/06/2025 at 11:16 p.m. revealed “Resident returned from [Hospital Name] on stretcher, two paramedics at side. Resident was placed on bed… under the services of [Physician Name] The next of kin was notified. The on-call Dr. [doctor] was recalled due to the wrong name that was given…Narcotic order was unable to be filled…” Review of a progress note for Resident #2 dated 08/07/2025 at 6:26 p.m. revealed “Pharmacy was notified of pending narcotic, spoke with [staff member name], who stated that medication would be out tonight. Writer then asked if she could have a code to remove a narcotic from EDK [Emergency Drug kit]. After several minutes, code was given, and pain pill was given to resident.” Review of physician orders for Resident #2 revealed: -2-view X-ray of left knee, start date 08/04/2025 with no end date. -Acetaminophen Tablet 325mg Give 2 tablets by mouth every 6 hours as needed for mild pain, pain level of 1-5 on pain scale, not to exceed 3 grams within 24-hour period, dated 6/25/2020. -Hydrocodone-Acetaminophen Oral Tablet 5-325MG Give 1 tablet by mouth as needed for pain. Give twice daily for acute pain, with a start date of 8/24/2025 and no end date. -Lidoderm External patch 5% (Lidocaine) apply to right front knee topically one time a day for 12 hours on and 12 hours off. “Remove per schedule and remove per schedule” Review of Resident #2's re-entry Minimum Data Set (MDS), dated [DATE], revealed Section C, Cognitive Patters, a Brief Interview for Mental Status (BIMS) score of 06 out of 15, indicating severely impaired cognition. Section GG revealed the resident had upper extremity impairment on one side and lower extremities impairment on both sides. The assessment revealed Resident #2 was dependent on activities of daily living to include: oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS coded Resident #2 as “dependent” meaning helper does ALL of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity. Under functional abilities, Resident #2 was assessed to be dependent to roll left and right. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/2025 at 1:32 p.m. an interview was conducted with Staff H, CNA. Staff H, CNA said Resident had not been eating that day and did not eat like she did prior to the fall. Staff H, CNA said Resident #2 is in pain all the time and had not been the same since the fall. She said, “The resident complains of pain all the time now. She does not want anyone to come near her,” and “she is scared we'll cause more pain when changing her”. Staff H, CNA stated Resident #2 was a two-person assist and was always dependent on two people because of contractures. Staff H, CNA said, “[Resident #2] is totally dependent on staff. She was at the time of the fall.” The CNA stated she heard the resident fell during care, but she was not working that day. An interview was conducted with Staff E, Registered Nurse (RN) on 08/24/2025 at 9:45 a.m. Staff E, RN stated Resident #2, fell recently, went to the hospital and is back now. Staff E, RN stated she was not present during the fall, but she knew the resident suffered a hip fracture and was sent out. She stated she heard the CNA was in the room when the fall occurred, but she could not speak of the details. An interview was conducted with Staff F, Licensed Practical Nurse (LPN) on 08/24/2025 at 1:35 p.m. Staff F, LPN stated Resident #2 complained of pain all the time since the fall. Staff F, LPN said the resident was typically assessed pain between a five or a six out ten on the pain scale. Staff F, LPN said, “She can't clearly say it. I don't think she can clearly articulate the levels, you can see it in her eyes though. She is in pain especially during care.” Staff F, LPN stated the CNAs are to make sure the resident had pillows for support and not bother her legs and hips. Staff F, LPN said at the time of the fall there were staffing concerns. There were only agency CNAs and nurses, she said. Staff F, LPN stated the Kardex (a care document showing a specific resident's care needs) for Resident #2 showed she was one person for bathing. Staff F, LPN stated the care plan still showed one staff for bathing. Staff F, LPN stated Resident #2 was contracted, had always been and that assessment would be confusing to staff. Staff F, LPN stated their regular staff knew the resident and they knew how to handle her. She stated there was supposed to be two staff for all care now. Review of the resident's narcotic log with Staff F, LPN confirmed even though the resident had been complaining of pain, there was no documentation pain medication been offered consistently. Staff F, LPN reviewed the log and confirmed there was no documentation of pain medication being administered on the day of the interview, despite the resident complaining of pain. Staff F, LPN stated she gave the resident pain medications but had not logged it. Staff F, LPN stated she gave it around 10:40 a. m. this morning, and said, “I got kind of busy, I did not log it yet. I will document now.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/2025 at 3:08 p.m. an interview was conducted with Staff D, Regional Nurse Consultant (RNC), and the Nursing Home Administrator (NHA). The NHA stated he was new and could not speak of the incident. The RNC stated on 08/03/2025 at 8:15 p.m., Resident #2 had a fall from her bed while staff were in the room to provide care. The RNC stated the staff member was Staff G, CNA who was a facility staff who worked as needed (PRN). The RNC said Staff G, CNA no longer worked at the facility. The RNC stated they immediately initiated an investigation into the fall incident. She said the facility's immediate report showed one person had been utilized for bed mobility resulting in a fall and fracture while the resident was care planned for two-person assistance. The RNC stated further investigation, and recreation of the incident identified the staff member was not touching the resident at the time of the fall. She stated the resident had contractures on knees and hips, and the head of the bed (HOB) was elevated. She stated the resident's abductor pillow had fallen between the bed and the wall, and the staff member was on the opposite side, setting items up for care. The RNC reported the resident pointed at the abductor pillow and reached then rolled over and fell to the right. The RNC confirmed the resident was supposed to be a two person assist during care. The RNC stated after the fall, they immediately evaluated Resident #2 with no pain or discomfort noted, so the resident was placed back in the bed. The RNC said the resident had a typical night but the next morning she reported knee pain. She said Acetaminophen was administered and an X-ray was ordered for the resident. The RNC stated on 08/05/2025, the resident reported more pain on the hips and since the X-ray tech did not come, the resident was sent to the hospital. The RNC stated the hospital identified the resident to have severe bone osteoarthritis and a femur fracture with mild tissue swelling in the left knee. The RNC stated the resident came back and had more medications ordered, and a perimeter mattress was also implemented. She stated as a precaution, abuse and neglect education was completed for all staff and instructions to follow the Kardex. The RNC read Staff G, CNA's written statement and said “I was assigned to patient, went in for care. She was shaking like she cold. I turned to get a sheet, and patient was on the floor. I called for help. Nurse came, both came and assess her and put her in bed.” The RNC stated the nurse's statements showed they assessed the resident and put the resident back to bed. The RNC stated Staff I, LPN evaluated the resident on the floor, while Staff J, LPN assisted, and they transferred her to bed. The RNC confirmed Resident #2's record did not show documentation of the assessment. There were no records of vitals or skin checks dated 08/03/2025. The RNC said, “The nurse did not document in the progress notes, and no vitals were documented. They should have.” The RNC said the provider was notified and the notes should be scanned in the electronic medical record. The RNC stated the provider ordered an X-ray on 08/04/2025 which was never fulfilled. The RNC stated when the X-ray is ordered, the expectation is that the technician is here within 24 hours. The RNC stated if it's ordered immediately (STAT), then the expectation was that the X-ray be performed faster. The RNC said, “I can't speak of the physician's decision not to order STAT. No one asked.” The RNC stated they administered Acetaminophen which was effective. She stated on 08/05/2025 the resident had more pain, was refusing care, and did not want to be moved. She stated the resident was crying and they called the doctor and sent the resident out. The RNC stated on the 3:00 p.m. to 11:00 p.m. shift, they received notification from the hospital reporting a femur fracture. The RNC said the facility immediately reported to all entities. She stated their findings identified that the CNA (Staff G, CNA) was in the room, she pulled the sheets and did not provide care. The RNC said Resident #2 fell before the staff member could help. She stated there were no staffing concerns at that time. The RNC said, “The CNA had gone into the room, was setting things up and did not touch resident, and the resident fell on her own, she was not being turned. ” She stated they did not identify findings of neglect, however they re-educated all staff on abuse and neglect. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's skin assessments for the month of August 2025 revealed only one assessment was completed, dated 08/12/2025 without any impairments noted. The review confirmed the care plan intervention initiated on 08/10/2025, to observe limb for swelling and skin changes was not implemented. During an interview with Staff K, OT on 09/08/25 at 1:04 p.m., she said she was working with Resident #2 on her upper body range of motion (ROM). She stated they were spending less time with the resident because, “the resident has been in a lot of pain lately”. Staff K, OT stated since the fall, the only change from therapy's perspective was to maintain low bed all the time and to offer pain medication if the resident requested. She stated she was not aware of any other interventions or any changes to the plan of care. Staff K, OT stated during therapy sessions, Resident #2 was obviously in pain sometimes. On 09/08/2025 at 10:47 a.m. an interview was conducted with Resident #2's primary care physician (PCP). The PCP confirmed seeing Resident #2 when they got out of the hospital, recently. The PCP stated they did not necessarily write notes every time they see patients. The PCP said the resident was bedridden and contracted on both sides. The PCP stated Resident #2 could not move self and the facility was trying to figure out how the resident would have gotten out of bed alone. The PCP said, “I told them I did not have an answer. The resident does not have bed mobility; “I do not believe [Resident #2] could have moved herself to the floor.” The PCP said they did not remember being called when the resident fell. The PCP confirmed being called “much later.” The PCP stated they did not know about the requested PCP follow-up. The PCP stated as far as the pain assessment, the resident now had the hip fracture and would have increased pain. The PCP stated, “It would have to be more pain, probably when they try to move [Resident #2].” The PCP stated they talked to the nurses during visits, but the nurses have been changing way too often, and they did not know if the nurses documented anything they discussed. The PCP stated the problem with the facility was they have been changing administration too often. The PCP said, “There is no continuation of care.” Review of physician notes for Resident #2 revealed the resident was seen by the PCP on 08/29/2025. The note revealed the resident … with right dominant side paresis, type 2 diabetes mellitus (DM), bilateral lower extremities (BLE) contractures and the documented associated comorbidities. Patient (pt) hospitalized for a fall from her bed resulting in a hip fracture. Patient seen for continuation of care. Staff do not report new concerns. The assessment and plan of care reviewed and documented below: Closed fracture of right hip with routine healing, subsequent encounter: Notes right intertrochanteric femoral fracture on CT 08/05/2025 status post (s/p) fall from bed. To be seen and be evaluated by ortho on 08/25. No surgical interventions as patient is bedbound at baseline has PRN meds. The note revealed, “Will likely need to be medicated when she needs to be moved /changed/bathed.” (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the facility's Medical Director (MD) on 09/08/2025 at 11:40 a.m. The MD stated Resident #2 was not his patient but heard about them in Quality Assurance and Performance Improvement (QAPI). The MD stated they discussed what happened and how they could prevent reoccurrence. The MD stated he did not remember specific details regarding Resident #2, but he would have expected the nursing staff to follow their policies and procedures post fall. He said for dependent residents, he would have expected to see two staff members providing care per the plan of care. He stated if a resident was found on the floor, he would expect the nurse to triage, assess, and see if the resident should be moved or not. He said if the on-call physician did not answer their phone, he would have expected staff to call 911. The MD stated all incidents should be documented at the time of injury. The MD stated the X-rays should be ordered STAT for a fall with reported pain, with an expectation for the orders to be fulfilled. He stated he did not know if the x-ray technician missed it. He stated either way, there should have been a follow -up. The MD stated the resident should have been sent out sooner and if the resident was in pain, the PCP should be contacted to evaluate if the interventions were working. He stated it should be documented. The MD stated when the resident is being sent out, the nurse should give the emergency medical team (EMT) the resident's information and current orders. He said staff should have contacted the PCP right away to obtain a new script if the one they received from the hospital had a wrong name. He said if the nurse could not reach the PCP, they have a process to follow, including contacting the MD. He stated Resident #2 should not have been waiting in pain because of a system issue or a process. The MD stated there should be documented on-going pain assessments with appropriate interventions. He stated if the resident suffered a fracture and was not a good candidate for surgery, then increased pain should be anticipated. The MD stated the facility had undergone challenges with some nurses who were let go. He stated they had a big problem with [Name of Healthcare Physician group]. He stated they lack in communication as the PCP's do not respond to phone calls. He stated the PCP's should be documenting after each visit and the notes should be in the resident's record. The MD stated he did not know why Resident #2 did not have any physician notes. On 09/08/2025 at 3:38 p.m. an interview with Staff D, RNC confirmed Resident #2 was not seen by her PCP until 08/29/2025. She stated she could not speak to the process. She stated the post discharge follow-up expected three to five days with PCP was not documented. On 09/09/2025 at 3:45 p.m. an interview was conducted with Staff O, CNA and Staff P, CNA. They stated Resident #2 had increased pain since the fall. Staff O, CNA said, “The resident now cries when you change them. [Resident #2] is afraid of being touched. When you try to put the brief between her legs the resident fringes, grimaces and pushes your hands away.” Staff P, CNA stated even before you start care, Resident #2 was anxious like she was waiting for the pain. Staff P, CNA stated it has been hard for the resident when she is changed. The CNAs stated the resident was not totally non-verbal and could communicate her needs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/10/2025 at 11:08 a.m. an interview was conducted with the Director of Rehabilitation (DOR) and Staff Q, Occupational Therapist (OT). Staff Q, OT stated having assessed Resident #2 post fall, and the resident was at baseline. She stated the resident required maximum assistance in bed, before and after the fall. Staff Q, OT said the resident was rolled side to side during a brief change from which the resident sustained a fall. Staff Q, OT stated they were waiting for orthopedics to follow up. Staff Q, OT stated the resident was agreeable to use the rail to practice roll log during care, to protect further movement and maintain midline positioning. Staff Q, OT said if Resident #2's legs were touched she was in pain. Staff Q, LPN said the resident refused to be cared for, “even before you touch [Resident #2], because of the pain.” The DOR stated two days ago they started training the CNAs on log rolling and to check with the nurse prior to care. The DOR said that training should have started when the resident returned from the hospital. 2. A review of Resident #5's admission Record showed an admission date of 07/12/2025 and readmissions on 08/16/2025 with the following diagnosis: sepsis, type 2 diabetes mellitus cerebral infarc

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 observation, interviews, and record review, the facility failed to provide the number of staff needed to ensure safety during bed mobility consistent with the assessed and care planned needs for four residents (#2, #3, #5 and #6) of five residents sampled for falls.Resident #2 sustained a fall from the bed during care, resulting in a transfer to a higher level of care due to acute pain and was diagnosed with a hip fracture. Resident #2, a vulnerable resident, was not promptly assessed post fall, and the resident's acute pain was not addressed in a timely manner. The facility failed to ensure Resident #2 was seen by a physician and that an ordered X-ray was completed. Resident #2, who was contracted and had other comorbidities, was not a candidate for surgical intervention resulting in on-going physical and psychosocial pain.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury or death to Residents #2 and resulted in the determination of Immediate Jeopardy on 09/10/2025. The findings of Immediate Jeopardy were determined to be removed on 09/10/2025 and the scope and severity was reduced to an E.Findings included: 1. On 08/24/2025 at 1:30 p.m. Resident #2 was observed in bed. The resident spoke very faintly and was able to nod to yes and no to questions. The resident said she had been in constant pain since the fall. The resident stated, “I have pain in my hip, a lot, medications are helping sometimes and sometimes I do not receive it [pain medication]”. The resident stated on the day of the fall, 08/03/2025, there was one staff member in the room providing care. Resident #2 stated, “[the staff member] was changing me. I was cold and needed my cover. I don't know what happened I just fell to the ground.” The resident said when the fall occurred that staff member yelled out to get help then two more staff members came and assisted the resident back to bed. The resident stated she did not get out of bed and reported feeling worse since the fall. Resident #2 reported being in pain and not being able to eat at the time of the interview. On 09/08/2025 at 1:00 p.m. an observation and interview were conducted with Resident #2. Resident #2's Power of Attorney (POA) and a family member were observed at the bedside brushing the resident's hair. The resident stated being okay, but was still in pain, Resident #2 said, “When they move me, it hurts. ” The resident said the nurse administered pain medication sometimes. Review of Resident #2's “admission Record” revealed Resident #2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur, initial encounter for closed fracture, onset date 08/06/2025. Other diagnoses included contracture of right shoulder, contracture unspecified joint, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unilateral osteoarthritis of right hip and left hip, muscle wasting and atrophy of right and left lower leg. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/25 at 5:33 p.m. a telephone interview was conducted with Staff G, Certified Nursing Assistant (CNA). Staff G, CNA confirmed they were assigned to Resident #2 on 08/03/2025 and went to their room around 7:30 p.m. to provide care. Staff G, CNA reported standing by Resident #2's bedside, caring for her, and had just pulled down the covers when the resident began pointing at the sheet and stated she was cold. Staff G, CNA said she was going to change the resident when the resident began shivering and shaking. Staff G, CNA stated, “I turned around to get the sheet and I said let me cover you. When I went to get the sheet and turned around, [Resident #2] was on the floor. I yelled out for help.” Staff G, CNA confirmed they were the only staff member in the room at the time of the fall and said there were no other CNAs on that hall. Staff G, CNA said two nurses came to the room and assessed Resident #2 and helped get the resident back in bed. Staff G, CNA stated she had provided care to Resident #2 prior to the incident with no other staff assisting, including bathing and changing, but only found out after the fall that the resident required two staff assistance. Staff G, CNA did not know if there was enough staff at the facility at the time of the fall. Staff G, CNA said the facility had agency nurses working that shift and there had originally been two CNAs on the back hall but, one of them may have left around 7:30 p.m. but Staff G, CNA didn't remember exactly and didn't know why they left. Staff G, CNA confirmed she did not ask for assistance to provide care to Resident #2 on 08/03/2025 due to everyone being busy. Staff G, CNA also stated she had only worked in the facility a few times prior to this incident and had not had any training on the care of Resident #2. On 09/08/2025 at 1:00 p.m. an interview was conducted with Resident #2's family member and their POA while they visited Resident #2. The family member and POA both restated their concerns. They stated on the day of the fall, the resident was being turned during care, there was only one staff member present, and the staff dropped the resident. The family stated Resident #2 was bedridden and when the resident fell on [DATE] the staff put the resident back in bed instead of getting the resident help. They reported there was no phone call made to the family about the resident's fall and the POA found out from another family member the resident was in the hospital. The family member and the POA stated when they went to the hospital, they had a hard time finding the resident due to Resident #2 being admitted with the wrong name. The family stated Resident #2 reported a lot of pain once they arrived. The family member said, “I asked what happened. [Resident #2] said they dropped me. I asked, Who dropped you? [Resident #2] said, the people at the nursing home. [Resident #2] said it was a lady, wearing a red weave [hair]. She was turning me. [Resident #2] said pointing on their hip, it hurts.” The family said Resident #2 explained that two men had assisted Resident #2 back to bed. The resident's family member stated they spoke with the attending physician at the hospital, and it was explained to them that the hospital tried to do surgery but had to rule it out due to the resident being contracted. The family stated Resident #2 was discharged back to the facility and they visited the following morning around 11:00 a.m. only to find Resident #2 crying, in pain, and had not had any pain medication. The family member said they spoke with the nurse and two CNAs who were sitting at the nurses' station and asked when Resident #2 had pain medication last. The nurse said they did not have pain medication for Resident #2 because the prescription came with the wrong name, and they had to resubmit the prescription. The family member said the nurse reported the last dose of pain medication Resident #2 had was at the hospital, the night before. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's progress note dated 08/03/2025 at 8:38 p.m. revealed, “Resident is post fall 20:15 [8:15 p.m.]. Per CNA, resident was being changed, and [Resident #2] rolled out of the bed. Resident denies hitting her head. Denies any pain or discomfort. No injury or bruising noted. Two person assist with transfer to bed. Call placed to [family member], at 10:25 p.m. Left message to call when available. Call placed to on-call for PCP [Primary Care Physician]. Awaiting return call. Resident is resting in bed watching TV [television]. No signs of acute distress or discomfort. Respirations are even and unlabored on room air. Bed in lowest locked position. Call light and side table within reach. Increased rounding for safety by nursing staff.” Review of Resident #2's care plan, revised on 11/02/2023 revealed “[Resident #2] has an ADL [activities of daily living] Self-Care Performance Deficit r/t [related to] impaired mobility due to CVA [cerebrovascular accident] with right sided hemiparesis.” The goal revealed “Will maintain current level of self performance with ADLs through next review.” The interventions included “BED MOBILITY: Dependent of 2 to turn and/or reposition Revision on: 01/09/2024. TRANSFER: TOTAL Mechanical lift to Chair of 2, Sling M [medium]. PERSONAL HYGIENE: dependent, initiated on 01/09/2024. DRESSING: Totally Dependent on staff for dressing. Date Initiated: 01/09/2024. TOILET USE: Dependent, Revision on: 01/09/2024.” Review of Resident #2's Fall care plan revised on 11/02/2023 revealed “[Resident #2] is at risk for falls or fall related injury because of: impaired mobility r/t Dx [diagnoses] Cva[sic] with Right hemiplegia, decreased safety awareness, and medication use.” The goal revealed “Will minimize the risk of falls through review date.” The interventions included “perimeter mattress, Date Initiated, 08/21/2025. Report falls to physician and responsible party, date Initiated, 05/04/2020. Provide environmental adaptations: Call light within reach, Date Initiated, 05/04/2020. Anticipate and meet the resident's needs, date initiated, 05/04/2020. Provide environmental adaptations: Adequate lighting, Date Initiated, 05/04/2020. Provide environmental adaptations: Area free of clutter, Date Initiated, 05/04/2020.” This review showed the new intervention was implemented 18 days after Resident #2's fall. Resident #2 had a care plan initiated on 08/10/25 that revealed “Resident #2 has a right femur Fracture.” The goal “Will remain free of complications related to hip fracture, such as contracture formation, embolism and immobility through review date.” The interventions revealed “Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Follow MD [Medical Doctor] orders for weight bearing status. See MD orders and/or PT [physical therapy] treatment plan. Modify environment as needed to meet current needs: non-slip surface for bath/shower, Bed in lowest position with wheels locked, Floors that are even and free from spills, clutter, Adequate, glare-free light. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. Observe limb for swelling and skin changes. Take pedal pulses as indicated. PT, OT [occupational therapy] evaluation and treatment per orders. Reposition as necessary to prevent skin breakdown. Prevent 90 degree flexion to prevent circulation problems.” Review of Resident #2's progress note dated 08/04/2025 at 10:50 a.m. revealed, “Patient reports left knee pain. PCP [primary care physician] made aware. Per PCP to order x-ray of left knee.” Review of the e-MAR (electronic Medication Administration Record) note dated 08/04/2025 at 11:02 a.m. revealed Resident #2 received Acetaminophen tablet 325 milligram (mg) for mild-moderate pain. “pt c/o [complained of] l [left] knee pain. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note for Resident #2 dated 08/05/2025 at 10:18 a.m. revealed “Resident with order for X-ray for pain. X-ray company unable to come promptly, order to send resident to ER [emergency room] for follow up.” Review of Resident #2's progress note dated 08/05/2025 at 11:44 a.m. revealed “Resident was transferred to the hospital.” Review of Resident #2's progress note, dated 08/05/2025 at 4:04 pm. Revealed “Nursing Assistant notified this transcriber that resident was crying due to right hip pain. Resident transferred to [Hospital] for further evaluation. MD notified.” Review of a progress note for Resident #2 dated 08/06/2025 at 1:22 a.m. revealed “called [Hospital]. at first and gave name of patient to see if she was admitted . [Hospital] stated they did not have her in their facility. resident[sic] put in their system with a different name. i[sic] called [Hospital A] and [Hospital B] and [Hospital C] to then call back [Hospital] to then use her birthday to ask again. her[sic] name was different in their system. resident[sic] was admitted with a right hip fracture on 8/5/25.” Review of Resident #2's hospital discharge summary for Resident #2 titled, “Final Report”, dated 08/05/2025 revealed “Chief Complaint ems [emergency medical services] from [Facility Name] unwitnessed fall from bed yesterday, left hip pain xray did not show up to facility, so sent here. deficits[sic] from prior stroke, dysphagia and right hemiplegia… History of Present Illness The patient is a [AGE] year-old, …who presents with left hip pain following a fall. The fall occurred yesterday at her nursing home and was unwitnessed; Staff found her on the floor complaining of left hip pain. An x-ray was ordered to be done at the facility, but the imaging team did not arrive. Due to ongoing pain and concern for fracture, she was sent to the emergency department for further evaluation. She is bedbound and severely contracted…A CT [Computed Tomography] of the pelvis was performed after plain films were abnormal but inconclusive, which confirmed an acute right hip fracture. …Chart Summary Patient is a poor surgical candidate. Patient is bedbound and contracted. No acute surgical intervention planned.” Review of the Hospital discharge medications list showed an order for Oxycodone 5 mg oral tablet, every 4 hours interval as needed for pain. Review of the hospital discharge instructions dated 08/06/2025 revealed “You Need to Schedule the Following Appointments” follow up with primary care provider, only if needed within 3-5 days, only if needed.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record for Resident #2 revealed there was no evidence of the physician seeing Resident #2 throughout the month of August 2025. On 08/24/2025 at 3:08 p.m. an interview was conducted with Staff D, Regional Nurse consultant (RNC), and the Nursing Home Administrator (NHA). The RNC stated the provider was notified of the resident's fall. The RNC confirmed there were no provider notes in the resident's record to confirm if the resident had been seen by a provider. Review of a progress note for Resident #2 dated 08/06/2025 at 11:16 p.m. revealed “Resident returned from [Hospital Name] on stretcher, two paramedics at side. Resident was placed on bed… under the services of [Physician Name] The next of kin was notified. The on-call Dr. [doctor] was recalled due to the wrong name that was given…Narcotic order was unable to be filled…” Review of a progress note for Resident #2 dated 08/07/2025 at 6:26 p.m. revealed “Pharmacy was notified of pending narcotic, spoke with [staff member name], who stated that medication would be out tonight. Writer then asked if she could have a code to remove a narcotic from EDK [Emergency Drug kit]. After several minutes, code was given, and pain pill was given to resident.” Review of physician orders for Resident #2 revealed: -2-view X-ray of left knee, start date 08/04/2025 with no end date. -Acetaminophen Tablet 325mg Give 2 tablets by mouth every 6 hours as needed for mild pain, pain level of 1-5 on pain scale, not to exceed 3 grams within 24-hour period, dated 6/25/2020. -Hydrocodone-Acetaminophen Oral Tablet 5-325MG Give 1 tablet by mouth as needed for pain. Give twice daily for acute pain, with a start date of 8/24/2025 and no end date. -Lidoderm External patch 5% (Lidocaine) apply to right front knee topically one time a day for 12 hours on and 12 hours off. “Remove per schedule and remove per schedule” Review of Resident #2's re-entry Minimum Data Set (MDS), dated [DATE], revealed Section C, Cognitive Patters, a Brief Interview for Mental Status (BIMS) score of 06 out of 15, indicating severely impaired cognition. Section GG revealed the resident had upper extremity impairment on one side and lower extremities impairment on both sides. The assessment revealed Resident #2 was dependent on activities of daily living to include: oral hygiene, toileting hygiene, shower/bathe, upper and lower body dressing, putting on/taking off footwear and personal hygiene. The MDS coded Resident #2 as “dependent” meaning helper does ALL of the effort and resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity. Under functional abilities, Resident #2 was assessed to be dependent to roll left and right. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/2025 at 1:32 p.m. an interview was conducted with Staff H, CNA. Staff H, CNA said Resident had not been eating that day and did not eat like she did prior to the fall. Staff H, CNA said Resident #2 is in pain all the time and had not been the same since the fall. She said, “The resident complains of pain all the time now. She does not want anyone to come near her,” and “she is scared we'll cause more pain when changing her”. Staff H, CNA stated Resident #2 was a two-person assist and was always dependent on two people because of contractures. Staff H, CNA said, “[Resident #2] is totally dependent on staff. She was at the time of the fall.” The CNA stated she heard the resident fell during care, but she was not working that day. An interview was conducted with Staff E, Registered Nurse (RN) on 08/24/2025 at 9:45 a.m. Staff E, RN stated Resident #2, fell recently, went to the hospital and is back now. Staff E, RN stated she was not present during the fall, but she knew the resident suffered a hip fracture and was sent out. She stated she heard the CNA was in the room when the fall occurred, but she could not speak of the details. An interview was conducted with Staff F, Licensed Practical Nurse (LPN) on 08/24/2025 at 1:35 p.m. Staff F, LPN stated Resident #2 complained of pain all the time since the fall. Staff F, LPN said the resident was typically assessed pain between a five or a six out ten on the pain scale. Staff F, LPN said, “She can't clearly say it. I don't think she can clearly articulate the levels, you can see it in her eyes though. She is in pain especially during care.” Staff F, LPN stated the CNAs are to make sure the resident had pillows for support and not bother her legs and hips. Staff F, LPN said at the time of the fall there were staffing concerns. There were only agency CNAs and nurses, she said. Staff F, LPN stated the Kardex (a care document showing a specific resident's care needs) for Resident #2 showed she was one person for bathing. Staff F, LPN stated the care plan still showed one staff for bathing. Staff F, LPN stated Resident #2 was contracted, had always been and that assessment would be confusing to staff. Staff F, LPN stated their regular staff knew the resident and they knew how to handle her. She stated there was supposed to be two staff for all care now. Review of the resident's narcotic log with Staff F, LPN confirmed even though the resident had been complaining of pain, there was no documentation pain medication been offered consistently. Staff F, LPN reviewed the log and confirmed there was no documentation of pain medication being administered on the day of the interview, despite the resident complaining of pain. Staff F, LPN stated she gave the resident pain medications but had not logged it. Staff F, LPN stated she gave it around 10:40 a. m. this morning, and said, “I got kind of busy, I did not log it yet. I will document now.” On 09/09/25 at 3:45 p.m. an interview was conducted with Staff O, CNA and Staff P, CNA. They stated Resident #2 had increased pain since the fall. Staff O, CNA said, “The resident now cries when you change them. [Resident #2] is afraid of being touched. When you try to put the brief between their legs the resident fringes, grimaces and pushes your hands away.” Staff P, CNA stated even before you start care, Resident #2 was anxious like they were waiting for the pain. Staff P, CNA stated it has been hard for the resident when they are changed. The CNAs stated the resident was not totally non-verbal and could communicate her needs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/10/2025 at 11:08 a.m. an interview was conducted with the Director of Rehabilitation (DOR) and Staff Q, Occupational Therapist (OT). Staff Q, OT stated having assessed Resident #2 post fall, and the resident was at baseline. She stated the resident required maximum assistance in bed, before and after the fall. Staff Q, OT said the resident was rolled side to side during a brief change from which the resident sustained a fall. Staff Q, OT stated they were waiting for orthopedics to follow up. Staff Q, OT stated the resident was agreeable to use the rail to practice roll log during care, to protect further movement and maintain midline positioning. Staff Q, OT said if Resident #2's legs were touched she was in pain. Staff Q, LPN said the resident refused to be cared for, “even before you touch [Resident #2], because of the pain.” The DOR stated two days ago they started training the CNAs on log rolling and to check with the nurse prior to care. The DOR said that training should have started when the resident returned from the hospital. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 08/24/2025 at 3:08 p.m. an interview was conducted with Staff D, Regional Nurse Consultant (RNC), and the Nursing Home Administrator (NHA). The NHA stated he was new and could not speak of the incident. The RNC stated on 08/03/2025 at 8:15 p.m., Resident #2 had a fall from her bed while staff were in the room to provide care. The RNC stated the staff member was Staff G, CNA who was a facility staff who worked as needed (PRN). The RNC said Staff G, CNA no longer worked at the facility. The RNC stated they immediately initiated an investigation into the fall incident. She said the facility's immediate report showed one person had been utilized for bed mobility resulting in a fall and fracture while the resident was care planned for two-person assistance. The RNC stated further investigation, and recreation of the incident identified the staff member was not touching the resident at the time of the fall. She stated the resident had contractures on knees and hips, and the head of the bed (HOB) was elevated. She stated the resident's abductor pillow had fallen between the bed and the wall, and the staff member was on the opposite side, setting items up for care. The RNC reported the resident pointed at the abductor pillow and reached then rolled over and fell to the right. The RNC confirmed the resident was supposed to be a two person assist during care. The RNC stated after the fall, they immediately evaluated Resident #2 with no pain or discomfort noted, so the resident was placed back in the bed. The RNC said the resident had a typical night but the next morning she reported knee pain. She said Acetaminophen was administered and an X-ray was ordered for the resident. The RNC stated on 08/05/2025, the resident reported more pain on the hips and since the X-ray tech did not come, the resident was sent to the hospital. The RNC stated the hospital identified the resident to have severe bone osteoarthritis and a femur fracture with mild tissue swelling in the left knee. The RNC stated the resident came back and had more medications ordered, and a perimeter mattress was also implemented. She stated as a precaution, abuse and neglect education was completed for all staff and instructions to follow the Kardex. The RNC read Staff G, CNA's written statement and said “I was assigned to patient, went in for care. She was shaking like she cold. I turned to get a sheet, and patient was on the floor. I called for help. Nurse came, both came and assess her and put her in bed.” The RNC stated the nurse's statements showed they assessed the resident and put the resident back to bed. The RNC stated Staff I, LPN evaluated the resident on the floor, while Staff J, LPN assisted, and they transferred her to bed. The RNC confirmed Resident #2's record did not show documentation of the assessment. There were no records of vitals or skin checks dated 08/03/2025. The RNC said, “The nurse did not document in the progress notes, and no vitals were documented. They should have.” The RNC said the provider was notified and the notes should be scanned in the electronic medical record. The RNC stated the provider ordered an X-ray on 08/04/2025 which was never fulfilled. The RNC stated when the X-ray is ordered, the expectation is that the technician is here within 24 hours. The RNC stated if it's ordered immediately (STAT), then the expectation was that the X-ray be performed faster. The RNC said, “I can't speak of the physician's decision not to order STAT. No one asked.” The RNC stated they administered Acetaminophen which was effective. She stated on 08/05/2025 the resident had more pain, was refusing care, and did not want to be moved. She stated the resident was crying and they called the doctor and sent the resident out. The RNC stated on the 3:00 p.m. to 11:00 p.m. shift, they received notification from the hospital reporting a femur fracture. The RNC said the facility immediately reported to all entities. She stated their findings identified that the CNA (Staff G, CNA) was in the room, she pulled the sheets and did not provide care. The RNC said Resident #2 fell before the staff member could help. She stated there were no staffing concerns at that time. The RNC said, “The CNA had gone into the room, was setting things up and did not touch resident, and the resident fell on her own, she was not being turned. ” She stated they did not identify findings of neglect, however they re-educated all staff on abuse and neglect. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's skin assessments for the month of August 2025 revealed only one assessment was completed, dated 08/12/2025 without any impairments noted. The review confirmed the care plan intervention initiated on 08/10/2025, to observe limb for swelling and skin changes was not implemented. During an interview with Staff K, OT on 09/08/25 at 1:04 p.m., she said she was working with Resident #2 on her upper body range of motion (ROM). She stated they were spending less time with the resident because, “the resident has been in a lot of pain lately”. Staff K, OT stated since the fall, the only change from therapy's perspective was to maintain low bed all the time and to offer pain medication if the resident requested. She stated she was not aware of any other interventions or any changes to the plan of care. Staff K, OT stated during therapy sessions, Resident #2 was obviously in pain sometimes. On 09/08/2025 at 10:47 a.m. an interview was conducted with Resident #2's primary care physician (PCP). The PCP confirmed seeing Resident #2 when they got out of the hospital, recently. The PCP stated they did not necessarily write notes every time they see patients. The PCP said the resident was bedridden and contracted on both sides. The PCP stated Resident #2 could not move self and the facility was trying to figure out how the resident would have gotten out of bed alone. The PCP said, “I told them I did not have an answer. The resident does not have bed mobility; “I do not believe [Resident #2] could have moved herself to the floor.” The PCP said they did not remember being called when the resident fell. The PCP confirmed being called “much later.” The PCP stated they did not know about the requested PCP follow-up. The PCP stated as far as the pain assessment, the resident now had the hip fracture and would have increased pain. The PCP stated, “It would have to be more pain, probably when they try to move [Resident #2].” The PCP stated they talked to the nurses during visits, but the nurses have been changing way too often, and they did not know if the nurses documented anything they discussed. The PCP stated the problem with the facility was they have been changing administration too often. The PCP said, “There is no continuation of care.” Review of physician notes for Resident #2 revealed the resident was seen by the PCP on 08/29/2025. The note revealed the resident … with right dominant side paresis, type 2 diabetes mellitus (DM), bilateral lower extremities (BLE) contractures and the documented associated comorbidities. Patient (pt) hospitalized for a fall from her bed resulting in a hip fracture. Patient seen for continuation of care. Staff do not report new concerns. The assessment and plan of care reviewed and documented below: Closed fracture of right hip with routine healing, subsequent encounter: Notes right intertrochanteric femoral fracture on CT 08/05/2025 status post (s/p) fall from bed. To be seen and be evaluated by ortho on 08/25. No surgical interventions as patient is bedbound at baseline has PRN meds. The note revealed, “Will likely need to be medicated when she needs to be moved /changed/bathed.” (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the facility's Medical Director (MD) on 09/08/2025 at 11:40 a.m. The MD stated Resident #2 was not his patient but heard about them in Quality Assurance and Performance Improvement (QAPI). The MD stated they discussed what happened and how they could prevent reoccurrence. The MD stated he did not remember specific details regarding Resident #2, but he would have expected the nursing staff to follow their policies and procedures post fall. He said for dependent residents, he would have expected to see two staff members providing care per the plan of care. He stated if a resident was found on the floor, he would expect the nurse to triage, assess, and see if the resident should be moved or not. He said if the on-call physician did not answer their phone, he would have expected staff to call 911. The MD stated all incidents should be documented at the time of injury. The MD stated the X-rays should be ordered STAT for a fall with reported pain, with an expectation for the orders to be fulfilled. He stated he did not know if the x-ray technician missed it. He stated either way, there should have been a follow -up. The MD stated the resident should have been sent out sooner and if the resident was in pain, the PCP should be contacted to evaluate if the interventions were working. He stated it should be documented. The MD stated when the resident is being sent out, the nurse should give the emergency medical team (EMT) the resident's information and current orders. He said staff should have contacted the PCP right away to obtain a new script if the one they received from the hospital had a wrong name. He said if the nurse could not reach the PCP, they have a process to follow, including contacting the MD. He stated Resident #2 should not have been waiting in pain because of a system issue or a process. The MD stated there should be documented on-going pain assessments with appropriate interventions. He stated if the resident suffered a fracture and was not a good candidate for surgery, then increased pain should be anticipated. The MD stated the facility had undergone challenges with some nurses who were let go. He stated they had a big problem with [Name of Healthcare Physician group]. He stated they lack in communication as the PCP's do not respond to phone calls. He stated the PCP's should be documenting after each visit and the notes should be in the resident's record. The MD stated he did not know why Resident #2 did not have any physician notes. On 09/08/2025 at 3:38 p.m. an interview with Staff D, RNC confirmed Resident #2 was not seen by her PCP until 08/29/2025. She stated she could not speak to the process. She stated the post discharge follow-up expected three to five days with PCP was not documented. 2. A review of the admission record for Resident #3 showed she was admitted to the facility on [DATE] with diagnoses including but not limited to anxiety disorder, unspecified, bipolar disorder, unsp

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure pain control and management for residents' post fall for two residents (#2 and #5) of three residents reviewed. Resident #2 sustained a femur fracture which she was not a surgical candidate for. Resident #2 continued to have uncontrolled pain which continued to affect her activities of daily living. The facility failed to accurately assess and notify the physician of Resident #2's uncontrolled pain. Resulting in on-going physical pain and psychosocial harm.Resident #2 sustained a fall from the bed during care, resulting in a transfer to a higher level of care due to acute pain and was diagnosed with a hip fracture. Resident #2, a vulnerable resident, was not promptly assessed post fall, and the resident's acute pain was not addressed in a timely manner. The facility failed to ensure Resident #2 was seen by a physician and that an ordered X-ray was completed. Resident #2, who was contracted and had other comorbidities, was not a candidate for surgical intervention resulting in on-going physical pain and psychosocial harm.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury or death to Residents #2 and resulted in the determination of Immediate Jeopardy on 09/10/2025. The findings of Immediate Jeopardy were determined to be removed on 09/10/2025 and the scope and severity was reduced to an E.Findings included: 1. On 08/24/2025 at 1:30 p.m. Resident #2 was observed in bed. The resident spoke very faintly and was able to nod to yes and no to questions. The resident said she had been in constant pain since the fall. The resident stated, “I have pain in my hip, a lot, medications are helping sometimes and sometimes I do not receive it [pain medication]”. The resident stated on the day of the fall, 08/03/2025, there was one staff member in the room providing care. Resident #2 stated, “[the staff member] was changing me. I was cold and needed my cover. I don't know what happened I just fell to the ground.” The resident said when the fall occurred that staff member yelled out to get help then two more staff members came and assisted the resident back to bed. The resident stated she did not get out of bed and reported feeling worse since the fall. Resident #2 reported being in pain and not being able to eat at the time of the interview. On 09/08/2025 at 1:00 p.m. an observation and interview were conducted with Resident #2. Resident #2's Power of Attorney (POA) and a family member were observed at the bedside brushing the resident's hair. The resident stated being okay, but was still in pain, Resident #2 said, “When they move me, it hurts. ” The resident said the nurse administered pain medication sometimes. On 09/09/25 at 3:45 p.m. an interview was conducted with Staff O, CNA and Staff P, CNA. They stated Resident #2 had increased pain since the fall. Staff O, CNA said, “The resident now cries when you change them. [Resident #2] is afraid of being touched. When you try to put the brief between their legs the resident fringes, grimaces and pushes your hands away.” Staff P, CNA stated even before you start care, Resident #2 was anxious like they were waiting for the pain. Staff P, CNA stated it has been hard for the resident when they are changed. The CNAs stated the resident was not totally non-verbal and could communicate her needs. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's “admission Record” revealed Resident #2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a primary diagnosis of displaced intertrochanteric fracture of right femur, initial encounter for closed fracture, onset date 08/06/2025. Other diagnoses included contracture of right shoulder, contracture unspecified joint, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unilateral osteoarthritis of right hip and left hip, muscle wasting and atrophy of right and left lower leg. On 08/24/25 at 5:33 p.m. a telephone interview was conducted with Staff G, Certified Nursing Assistant (CNA). Staff G, CNA confirmed they were assigned to Resident #2 on 08/03/2025 and went to their room around 7:30 p.m. to provide care. Staff G, CNA reported standing by Resident #2's bedside, caring for her, and had just pulled down the covers when the resident began pointing at the sheet and stated she was cold. Staff G, CNA said she was going to change the resident when the resident began shivering and shaking. Staff G, CNA stated, “I turned around to get the sheet and I said let me cover you. When I went to get the sheet and turned around, [Resident #2] was on the floor. I yelled out for help.” Staff G, CNA confirmed they were the only staff member in the room at the time of the fall and said there were no other CNAs on that hall. Staff G, CNA said two nurses came to the room and assessed Resident #2 and helped get the resident back in bed. Staff G, CNA stated she had provided care to Resident #2 prior to the incident with no other staff assisting, including bathing and changing, but only found out after the fall that the resident required two staff assistance. Staff G, CNA did not know if there was enough staff at the facility at the time of the fall. Staff G, CNA said the facility had agency nurses working that shift and there had originally been two CNAs on the back hall but, one of them may have left around 7:30 p.m. but Staff G, CNA didn't remember exactly and didn't know why they left. Staff G, CNA confirmed she did not ask for assistance to provide care to Resident #2 on 08/03/2025 due to everyone being busy. Staff G, CNA also stated she had only worked in the facility a few times prior to this incident and had not had any training on the care of Resident #2. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/08/2025 at 1:00 p.m. an interview was conducted with Resident #2's family member and their POA while they visited Resident #2. The family member and POA both restated their concerns. They stated on the day of the fall, the resident was being turned during care, there was only one staff member present, and the staff dropped the resident. The family stated Resident #2 was bedridden and when the resident fell on [DATE] the staff put the resident back in bed instead of getting the resident help. They reported there was no phone call made to the family about the resident's fall and the POA found out from another family member the resident was in the hospital. The family member and the POA stated when they went to the hospital, they had a hard time finding the resident due to Resident #2 being admitted with the wrong name. The family stated Resident #2 reported a lot of pain once they arrived. The family member said, “I asked what happened. [Resident #2] said they dropped me. I asked, Who dropped you? [Resident #2] said, the people at the nursing home. [Resident #2] said it was a lady, wearing a red weave [hair]. She was turning me. [Resident #2] said pointing on their hip, it hurts.” The family said Resident #2 explained that two men had assisted Resident #2 back to bed. The resident's family member stated they spoke with the attending physician at the hospital, and it was explained to them that the hospital tried to do surgery but had to rule it out due to the resident being contracted. The family stated Resident #2 was discharged back to the facility and they visited the following morning around 11:00 a.m. only to find Resident #2 crying, in pain, and had not had any pain medication. The family member said they spoke with the nurse and two CNAs who were sitting at the nurses' station and asked when Resident #2 had pain medication last. The nurse said they did not have pain medication for Resident #2 because the prescription came with the wrong name, and they had to resubmit the prescription. The family member said the nurse reported the last dose of pain medication Resident #2 had was at the hospital, the night before. Review of Resident #2's progress note dated 08/03/2025 at 8:38 p.m. revealed, “Resident is post fall 20:15 [8:15 p.m.]. Per CNA, resident was being changed, and [Resident #2] rolled out of the bed. Resident denies hitting her head. Denies any pain or discomfort. No injury or bruising noted. Two person assist with transfer to bed. Call placed to [family member], at 10:25 p.m. Left message to call when available. Call placed to on-call for PCP [Primary Care Physician]. Awaiting return call. Resident is resting in bed watching TV [television]. No signs of acute distress or discomfort. Respirations are even and unlabored on room air. Bed in lowest locked position. Call light and side table within reach. Increased rounding for safety by nursing staff.” (continued on next page)

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Concordia Manor	321 13th Ave N Saint Petersburg, FL 33701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's care plan, revised on 11/02/2023 revealed “[Resident #2] has an ADL [activities of daily living] Self-Care Performance Deficit r/t [related to] impaired mobility due to CVA [cerebrovascular accident] with right sided hemiparesis.” The goal revealed “Will maintain current level of self performance with ADLs through next review.” The interventions included “BED MOBILITY: Dependent of 2 to turn and/or reposition Revision on: 01/09/2024. TRANSFER: TOTAL Mechanical lift to Chair of 2, Sling M [medium]. PERSONAL HYGIENE: dependent, initiated on 01/09/2024. DRESSING: Totally Dependent on staff for dressing. Date Initiated: 01/09/2024. TOILET USE: Dependent, Revision on: 01/09/2024.” Review of Resident #2's Fall care plan revised on 11/02/2023 revealed “[Resident #2] is at risk for falls or fall related injury because of: impaired mobility r/t Dx [diagnoses] Cva[sic] with Right hemiplegia, decreased safety awareness, and medication use.” The goal revealed “Will minimize the risk of falls through review date.” The interventions included “perimeter mattress, Date Initiated, 08/21/2025. Report falls to physician and responsible party, date Initiated, 05/04/2020. Provide environmental adaptations: Call light within reach, Date Initiated, 05/04/2020. Anticipate and meet the resident's needs, date initiated, 05/04/2020. Provide environmental adaptations: Adequate lighting, Date Initiated, 05/04/2020. Provide environmental adaptations: Area free of clutter, Date Initiated, 05/04/2020.” This review showed the new intervention was implemented 18 days after Resident #2's fall. Resident #2 had a care plan initiated on 08/10/25 that revealed “Resident #2 has a right femur Fracture.” The goal “Will remain free of complications related to hip fracture, such as contracture formation, embolism and immobility through review date.” The interventions revealed “Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Follow MD [Medical Doctor] orders for weight bearing status. See MD orders and/or PT [physical therapy] treatment plan. Modify environment as needed to meet current needs: non-slip surface for bath/shower, Bed in lowest position with wheels locked, Floors that are even and free from spills, clutter, Adequate, glare-free light. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. Observe limb for swelling and skin changes. Take pedal pulses as indicated. PT, OT [occupational therapy] evaluation and treatment per orders. Reposition as necessary to prevent skin breakdown. Prevent 90 degree flexion to prevent circulation problems.” Review of Resident #2's progress note dated 08/04/2025 at 10:50 a.m. revealed, “Patient reports left knee pain. PCP [primary care physician] made aware. Per PCP to order x-ray of left knee.” Review of the e-MAR (electronic Medication Administration Record) note dated 08/04/2025 at 11:02 a.m. revealed Resident #2 received Acetaminophen tablet 325 milligram (mg) for mild-moderate pain. “pt c/o [complained of] l [left] knee pain. Review of a progress note for Resident #2 dated 08/05/2025 at 10:18 a.m. revealed “Resident with order for X-ray for pain. X-ray company unable to come promptly, order to send resident to ER [emergency room] for follow up.” Review of Resident #2's progress note dated 08/05/2025 at 11:44 a.m. revealed “Resident was transferred to the hospital.” Review of Resident #2's progress note, dated 08/05/2025 at 4:04 pm. Revealed “Nursing Assistant notified this transcriber that resident was crying due to right hip pain. Resident transferred to [Hospital] for further evaluation. MD notified.” (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note for Resident #2 dated 08/06/2025 at 1:22 a.m. revealed “called [Hospital]. at first and gave name of patient to see if she was admitted . [Hospital] stated they did not have her in their facility. resident[sic] put in their system with a different name. i[sic] called [Hospital A] and [Hospital B] and [Hospital C] to then call back [Hospital] to then use her birthday to ask again. her[sic] name was different in their system. resident[sic] was admitted with a right hip fracture on 8/5/25.” Review of Resident #2's hospital discharge summary for Resident #2 titled, “Final Report”, dated 08/05/2025 revealed “Chief Complaint ems [emergency medical services] from [Facility Name] unwitnessed fall from bed yesterday, left hip pain xray did not show up to facility, so sent here. deficits[sic] from prior stroke, dysphagia and right hemiplegia… History of Present Illness The patient is a [AGE] year-old, …who presents with left hip pain following a fall. The fall occurred yesterday at her nursing home and was unwitnessed; Staff found her on the floor complaining of left hip pain. An x-ray was ordered to be done at the facility, but the imaging team did not arrive. Due to ongoing pain and concern for fracture, she was sent to the emergency department for further evaluation. She is bedbound and severely contracted…A CT [Computed Tomography] of the pelvis was performed after plain films were abnormal but inconclusive, which confirmed an acute right hip fracture. …Chart Summary Patient is a poor surgical candidate. Patient is bedbound and contracted. No acute surgical intervention planned.” Review of the Hospital discharge medications list showed an order for Oxycodone 5 mg oral tablet, every 4 hours interval as needed for pain. Review of the hospital discharge instructions dated 08/06/2025 revealed “You Need to Schedule the Following Appointments” follow up with primary care provider, only if needed within 3-5 days, only if needed.” Review of the medical record for Resident #2 revealed there was no evidence of the physician seeing Resident #2 throughout the month of August 2025. On 08/24/2025 at 3:08 p.m. an interview was conducted with Staff D, Regional Nurse consultant (RNC), and the Nursing Home Administrator (NHA). The RNC stated the provider was notified of the resident's fall. The RNC confirmed there were no provider notes in the resident's record to confirm if the resident had been seen by a provider. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a progress note for Resident #2 dated 08/06/2025 at 11:16 p.m. revealed “Resident returned from [Hospital Name] on stretcher, two paramedics at side. Resident was placed on bed… under the services of [Physician Name] The next of kin was notified. The on-call Dr. [doctor] was recalled due to the wrong name that was given…Narcotic order was unable to be filled…” Review of a progress note for Resident #2 dated 08/07/2025 at 6:26 p.m. revealed “Pharmacy was notified of pending narcotic, spoke with [staff member name], who stated that medication would be out tonight. Writer then asked if she could have a code to remove a narcotic from EDK [Emergency Drug kit]. After several minutes, code was given, and pain pill was given to resident.” Review of a Physical Therapy (PT) encounter progress note for Resident #2 dated 08/29/2025 showed, pt. (patient) visited multiple times today in order to recruit improved bed mobility with mod A (moderate assistance) to rolling to maintenance and repositioning in midline with reinforcement given to maximize midline posture with multiple visits and encouragement given to improve participation however pt. (patient) demonstrate reluctance to further mobility. Review of a Physical Therapy (PT) encounter progress note for Resident #2 dated 08/11/2025 showed… patient is very apprehensive and anxious due to pain R (right) leg… Review of a Physical Therapy (PT) encounter progress note for Resident #2 dated 08/13/2025 showed… Patient is very anxious about attempting to roll onto back and takes a long time to become ready for an attempt. Review of a Physical Therapy (PT) encounter progress note for Resident #2 dated 08/21/2025 showed… STM to BL (Soft Tissue Mobilization to Bilateral Stimulation) legs to ease discomfort and reduce patient anxiety around movement, pt. state legs and hip hurt daily. Review of a Physical Therapy (PT) encounter progress note for Resident #2 dated 08/26/2025 showed… patient requires extra time to complete full log roll and can become very combative when not in the mood or fearful of possible pain or discomfort. Review of physician orders for Resident #2 revealed: -2-view X-ray of left knee, start date 08/04/2025 with no end date. -Acetaminophen Tablet 325mg Give 2 tablets by mouth every 6 hours as needed for mild pain, pain level of 1-5 on pain scale, not to exceed 3 grams within 24-hour period, dated 6/25/2020. -Hydrocodone-Acetaminophen Oral Tablet 5-325MG Give 1 tablet by mouth as needed for pain. Give twice daily for acute pain, with a start date of 8/24/2025 and no end date. -Lidoderm External patch 5% (Lidocaine) apply to right front knee topically one time a day for 12 hours on and 12 hours off. “Remove per schedule and remove per schedule” (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 09/09/2025 at 3:11 p.m. an interview was conducted with Staff M, Physical Therapy Assistant (PTA) and Staff N, Occupational Therapist (OT). Staff N, PTA stated Resident #2 was on therapy for a while trying to get her to be mobile and some range of motion for right arm splinting, working on tolerating two orthotics. Staff N, OT stated they were working on reaching and biomotor abilities (the fundamental physical and motor qualities that determine an individual's athletic potential and ability to perform physical tasks) for other hand due to contractures. Staff N, OT stated for ADLs (activities of daily living), Resident #2 can do some minor tasks, but requires max assistance from staff. She stated Resident #2 does not tolerate any position or lying. Staff N, OT said, “He/She is not able to move left/right. The hips and legs don't turn. The upper body can't face the wall. I have never seen her adjust self. She is not able.” Staff N, OT stated the resident is in a lot of pain from the contractures and needed assistance with lower bed mobility and was dependent on transfers. She stated for interventions post fall the IDT (interdisciplinary team) would have met and discussed the changes. Staff N, OT stated the change she had noted since the fall was that Resident #2 is non-weight bearing because of the fracture. Staff N, OT stated changes to the care plan would have been discussed with the IDT team, who should pass it on to nursing. The Kardex should reflect the most recent plan of care. Staff N, OT stated when Resident #2 came from the hospital she was assessed, but there was no change in her general functional baseline, except she seems like there is increased pain. Staff N, OT said, “[Resident #2] had increased fear, when repositioning her legs she shakes her head. She says she is nervous with brief change.” Staff M, PTA stated the interventions for pain would be on-going. Staff M, PTA stated Resident #2 should be assessed prior to any task. Staff M, PTA stated in-services on bed mobility were initiated, on 09/08/2025 to logroll the resident during care. The interventions and expectations for CNAs should be put in the task sheet or Kardex. On 09/10/2025 at 11:08 a.m. an interview was conducted with the Director of Rehabilitation (DOR) and Staff Q, Occupational Therapist (OT). Staff Q, OT stated having assessed Resident #2 post fall, and the resident was at baseline. She stated the resident required maximum assistance in bed, before and after the fall. Staff Q, OT said the resident was rolled side to side during a brief change from which the resident sustained a fall. Staff Q, OT stated they were waiting for orthopedics to follow up. Staff Q, OT stated the resident was agreeable to use the rail to practice roll log during care, to protect further movement and maintain midline positioning. Staff Q, OT said if Resident #2's legs were touched she was in pain. Staff Q, LPN said the resident refused to be cared for, “even before you touch [Resident #2], because of the pain.” The DOR stated two days ago they started training the CNAs on log rolling and to check with the nurse prior to care. The DOR said that training should have started when the resident returned from the hospital. (continued on next page)

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