STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106072	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Place Healthcare and Rehabilitation Center	2370 Harbor Blvd Port Charlotte, FL 33952

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policies and procedures, and staff interviews, the facility failed to protect residents' rights to be free from neglect by failing to follow established processes to document and report a resident's fall to ensure timely and appropriate post-fall evaluation for 1 (Resident #900) of 3 residents reviewed. Resident #900 had severe cognitive impairment and required substantial to maximal assistance with activities of daily living, including transfers. On 4/17/25 at 7:30 p.m., Resident #900 was found on the floor in his room. The licensed nurse on duty failed to document the fall, failed to evaluate the resident for injuries such as fractures, and failed to notify the Director of Nursing or physician of the fall. On 4/18/25 the Physical Therapist documented Resident #900 verbalized right knee pain with all mobility and pain to the right groin/hip area but neglected to communicate the change in condition to the nursing department for appropriate follow-up. On 4/18/25 the Unit Manager wrote an order for an X-Ray of the resident's right hip. The x-ray was never done but the nurse marked the X-ray as completed. On 4/24/25 Resident #900 was emergently transferred to the local hospital for altered mental status and abnormal labs. The resident's spouse reported he had a fall at the facility and has not been ambulatory since then and has not been his normal self. A CT (computerized tomography) scan obtained at the hospital on 4/24/25 at 3:55 p.m., showed a comminuted intertrochanteric right femoral fracture and an acute L4 (lumbar vertebra)anterior superior endplate fracture. The facility failure to implement processes to prevent neglect created a likelihood of serious harm, serious injury or death of Resident #900 and other residents from complication of falls, including untreated fractures which could result in severe pain, severe bone infection, delayed healing, and deformity. This failure resulted in the determination of Immediate Jeopardy. The findings included: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross Reference F689, F726, and F835. Review of the facility's policy titled Abuse Prevention Program revised December 2016 noted, Our residents have the right to be free from .neglect . As part of the resident abuse prevention, the administration will . Develop and implement policies and procedures to aid our facility in preventing . neglect . of our residents. Review of the facility's policy titled, Abuse and Neglect-Clinical Protocol revised March 2018 revealed, Neglect . means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . Assessment and recognition. The nurse will assess the individual and document related findings, including: a. Injury assessment (bleeding, bruising, deformity, swelling etc.) b. Pain assessment . The nurse will report findings to the physician. Along with staff and management, the physician will help identify situations that might constitute or could be construed as neglect. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of . neglect. The Medical Director will advise facility management and staff about ways to ensure that basic medical, functional, and psychological needs are being met and potentially preventable and treatable conditions affecting function and quality of life are addressed appropriately. Review of the clinical record revealed Resident #900 was an [AGE] years old male admitted to the facility on [DATE]. Diagnoses included vascular dementia, muscle weakness and the need for assistance with personal care. Review of the admission Minimum Data Set (MDS) assessment with a target date of 4/18/25 revealed Resident #900's cognitive skills for daily decision making were severely impaired. Resident #900 required substantial to maximal assistance with activities of daily living, including toileting and bed mobility. The MDS noted transfer and ambulation were not attempted due to medical condition or safety concerns. Review of the admission Nursing Comprehensive evaluation dated 4/14/25 revealed Resident #900 score 10 on the fall risk evaluation. The form noted a score of 10 or higher indicates risk for falls. The baseline care plan for falls/Mobility and Bowel/Bladder needs dated 4/14/25 noted the goal for Resident #900 was to remain free from fall related injury. The interventions included to provide hands on assist of 2 with pivot transfers, provide hands on assist with walking, use the sit-stand lift with 2 staff for transfers, assist with incontinent care, provide supervision with toileting. On 4/17/25 at 8:00 p.m., a Fall Risk Evaluation noted a Fall Risk Score of 14. The form noted the most recent fall was 4/17/2025. The clinical record lacked documentation the fall was investigated, and interventions put into place to prevent further incidents of avoidable falls. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/18/25 at 2:14 p.m., Unit Manager Registered Nurse (RN) Staff B wrote a physician's order for 2 view X-ray of the right hip and knee one time only. On 4/18/25 at 2:23 p.m., the Physical Therapy Assistant (PTA) documented in a Physical Therapy treatment encounter note Resident #900 verbalized right knee pain with all mobility tasks and also pointing to groin/hip area verbalizing pain. The PTA documented a note was left in the Attending Physician's folder and the Director of Rehab was notified. There was no documentation the change of condition was communicated to the nursing department. On 4/18/25 at 9:46 p.m., RN Staff C placed a check mark and her initials on the Treatment Administration Record (TAR) verifying the X-ray of Resident #900's right hip was done. Complete review of the clinical record failed to reveal documentation of results for Right hip X-ray. On 4/23/25 the Occupational Therapist documented in a progress note that Resident #900 had declined in functional mobility tasks, requiring maximum assist and transfer to the wheelchair with maximum assistance of 2. Review of the Medication Administration Record (MAR) for April 2025 revealed a physician's order dated 4/15/25 to evaluate Resident #900 for pain every shift. The MAR noted on 4/18/25 the resident's pain level was 1 (mild pain). A pain level of 0 was entered for all other day and evening shifts. On 4/24/25 at 12:00 a.m., a hospital transfer form noted Resident #900 was emergently transferred to the hospital. The reason for the transfer was, Altered mental status. On 6/5/25 at 10:30 a.m., during an interview the Director of Nursing (DON) was asked about the result of Resident #900's right hip X-ray for 4/18/25 and the fall investigation for 4/17/25. The DON denied knowledge of the fall of 4/17/25. She stated, The resident never had a fall at the facility. She said Resident #900 was sent to the local emergency room (ER) on 4/23/25 for altered mental status. She said she did not know the fall risk evaluation completed on 4/17/25 noted the resident sustained a fall on 4/17/25 and was not aware of an order for a right hip X-ray on 4/18/25 for Resident #900. On 6/5/25 at 11:00 a.m., in an interview Unit Manager RN Staff B verified on 4/18/25 she entered a physician's order in Resident #900's record for a 2 view X-ray of the right hip and knee. She denied knowledge of Resident #900's fall on 4/17/25 and said, I don't know why I entered the physician's order for the X-ray. When asked about the results of the X-ray, RN Staff B said the X-ray was never done. RN Staff B said there was no formal logbook or system in place to track diagnostic orders like X-rays to ensure they were done. She said after a resident's fall, they notify the DON, the physician and the resident's family. She confirmed the lack of documentation the physician and the DON were notified of Resident #900's fall on 4/17/25. She said, From what I can see, that wasn't done. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/5/25 at 12:50 p.m., in an interview the DON said she became aware Resident #900 had a fall on 4/17/25 today, during the investigation. The DON confirmed there was no documentation that the fall was reported to her at the time it occurred and no internal investigation or corrective actions were initiated. She said the responsibilities of the nursing staff included the nurse would complete an incident report and report the fall directly to her. The DON said the facility ' s standard fall response protocol is: The staff member who finds the resident notifies the nurse. The nurse performs an injury assessment and questions the resident. The environment is evaluated (bed, call light, non-slip socks, wheelchair, etc.). If no injury, the resident is assisted back to bed. If there is an emergency injury the on-call physician is notified and the resident is sent to emergency room. The DON, Nursing Home Administrator (NHA), the physician, and family are to be notified. A risk incident report must be completed. If transferred to the hospital, a transfer form is completed. The DON said if a Risk report was entered by the nurse, it was her role to confirm the fall response was completed and all parties were notified. She said she determines immediate interventions and ensures care plan updates are made the next business day. She completes a 24-hour report review every morning from the Risk report. The DON said there were no measures in place if a risk or progress note is not entered and it does not trigger her 24-hour incident report, she stated, There has to be more nursing education because this step cannot be missed. On 6/6/25 at 8:44 a.m., in a telephone interview Licensed Practical Nurse (LPN) Staff A confirmed on 4/17/25 Resident #900 was found on the floor in his room. She said he was attempting to toilet himself. LPN Staff A said the resident fell due to weakness. She said she notified the DON and the Physician but verified the lack of documentation in the clinical record the DON and physician were notified of the fall. LPN Staff A said she could not recall if she contacted the resident's family. Staff A said after the fall she did not put any interventions in place to prevent future falls. She said she did not document the fall on the 24-hour shift report for the next shift to provide follow-up care. She said she did not obtain the order for the right knee and hip X-ray. Review of the hospital record revealed Resident #900 was admitted on [DATE]. The hospital course noted the resident was sent to the emergency room (ER) from the nursing facility for abnormal labs and altered mental status. The resident was recently admitted to the facility on [DATE]th through the 14th after having a non-syncopal fall. The resident was discharged to a nursing facility. According to the resident's spouse, Resident #900 was doing well and walking while he was there. He had a fall on the 2nd day at the nursing facility and has not been ambulatory since then and has not been acting his normal self. A CT scan of the abdomen and pelvis dated 4/24/25 at 3:45 p.m., noted an acute appearing L4 (4th lumbar vertebra) anterior superior endplate fracture. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A CT of the right lower extremity dated 4/24/25 at 3:55 p.m. revealed a comminuted (broken in multiple pieces) intertrochanteric right femoral fracture. Adjacent fluid and hematoma (collection of clotted blood) with stranding (indication of bleeding and inflammation in the injured area). On 6/6/25 at 3:14 p.m., in an interview Resident #900's attending physician and Medical Director said, I would love to tell you yes, that I was notified of [Resident #900]'s fall but I was not. If I could bring something to you, I would have it in my hands to give to you. He said he was notified on 6/5/25 of the incident. He said he tried to track down the order for the right hip X-ray but did not know who gave that order. The attending physician said the process is to notify his Advanced Practice Registered Nurse (APRN). If the APRN does not return the call in an hour, it will come to him. If it is urgent, they notify him or his partner. When an order is given, the process to ensure follow-up depends. Normal, non-urgent things will come that day or the next day so they can see the patient. The physician or the APRN are to follow up on adverse events. The physician said, I do not know what happened with this process with this patient. The physician said he reviewed Resident #900's entire file and went over the case with the APRN. He said, I don't have an answer as to why I was not notified of the fall and why it was not documented. We found nothing. He said, I do not remember getting a call about (Resident #900) having pain. They had nothing documented. On 6/6/25 at 4:12 p.m., an interview was held with the DON to discuss processes in place to prevent neglect and address residents' incidents. The DON said during stand up meetings in the morning all the management team is present. The management team goes over risk concerns and handle concerns right then and there. They review falls, risk and that kind of things. The incident reporting system notifies them of falls. A progress note is sometimes put in and it comes up on the 24 hour report. If the nurse does not write a note about an incident, the concern does not populate in the 24 hour report. The evaluations, including fall evaluations do not trigger on the 24 hour report. When she goes into the risk system she reviews the progress notes and if anything is missed they call the nurse back in. They follow up with falls for 72 hours so there should be documentation. The DON said, I found a break in our process. There has never been a review of orders put in. I would not know if a nurse took an order and did not put it in the system. I do not like nurses putting verbal orders in the system. I feel like it is a strong system if the physician or Nurse Practitioner put the orders in and we confirm. The DON said currently they did not have a 3-11 shift or an 11-7 shift supervisor. She said, The nurses are in charge of the building at night. I would have to speak with the Administrator about how to notify the nurses of who is in charge. Right now, we do not have anything. On 6/10/25 at 3:40 p.m., in an interview the Director of Rehab said he instructed his staff to document and report any changes, refusal of services to him and Unit Manager RN Staff B. He said he was the one who attended morning meetings and made sure he brought the concerns with him. He said the rehab department computer system does not pair with the electronic system used by the facility. He said he has always emailed any resident concerns to the DON. They also write their concerns in the physician binder located at the nurse's desk. The DOR said he did not have the email to the DON related to Resident #900's complaint of pain on 4/18/25. He said he attended the morning meeting and reported it to the interdisciplinary team. A review of the physician binder at the nurse's station failed to reveal documentation of the resident's complaint of pain on 4/18/25. The binder was empty. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/11/25 the immediate actions implemented by the facility and verified by the survey team included: On 6/11/25 the DON and Administrator verified the Licensed Nurse who failed to assess the resident and complete the incident report was suspended. On 6/11/25 the survey team verified through review of the in-service dated 6/7/25 that the Regional nurse educated the Unit Manager who entered the x-ray order but did not follow up. The Unit Manager was educated on her job description, following up on physicians' orders, following up on daily tasks assigned and consistently training staff on her unit. On 6/11/25 the survey team verified through record review and interview with the DON and Administrator the Regional Nurse reviewed their job description to ensure oversight and effective monitoring is maintained to ensure competency of staff to provide safe nursing care and related services to meet the needs of residents and prevent the neglect of residents. Both signed a new job description. On 6/11/25 the survey team verified on 6/8/25 that the Director of Rehab educated the therapy department staff regarding changes in condition and falls. The education included the changes needed to be communicated to the Director of Rehabilitation or designee who will then report the findings to the DON/designee via email immediately. On 6/11/25 the survey team verified through review of in-service records that on June 7, 2025, and June 8, 2025, the Human Resources Director and the Administrator educated 136 of 145 staff on reporting of any suspicion of abuse or neglect. Staff were provided a name badge that outlines who to contact if they suspect any form of abuse or neglect. The supervisor will immediately notify the abuse coordinator (Administrator) who in turn will immediately notify the Department of Children and Families, law enforcement and the Agency for Health Care Administration. Observation revealed staff wearing new badges with names and contact numbers for abuse reporting. On 6/11/25 the survey team verified through record review that 34 of 36 licensed nurses completed training on the facility's new incident reporting system. The DON and Administrator provided information and demonstrated how the new incident reporting system worked and all incidents are reviewed internally by the DON, Assistant Director of Nursing (ADON), the Nurse Consultant and Administrator. The incident reports are also monitored and reviewed by an outside contracted consulting services. On 6/11/25 the survey team verified through record review and interview with the Administrator that the facility had an Ad Hoc QAPI (unplanned Quality Assurance and Performance Improvement) meeting on 6/6/25. They reviewed system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, including the Medical Director. On 6/11/25 the survey team verified through record review and interview with the DON that as of 6/7/25, daily order listing reports and daily 24-hour reports were initiated and are being reviewed daily by the DON or designee. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/11/25 the survey team verified that as of June 8, 2025, the Regional Nurse educated 21 of 21 administration staff on abuse training and reporting training. The survey team verified administration staff educated included DON, Administrator, ADON, Unit Manager, MDS nurses (2), Social Services (2), Wound Care Nurse, Human Resources Director, Maintenance Director, Therapy Director, Activities Director, Business Office Manager, Staffing Coordinator, Certified Dietary Manager (CDM), Admission. On 6/11/25 the survey team verified that as of June 8, 2025, 136 of 145 staff have completed the required abuse training. The survey team verified that staff who have not completed the required training will not be allowed to work or will not be scheduled to work until the training is completed. The education and competencies were done by nursing management, including the DON, ADON, Wound Nurse, Department Managers and Regional Nurse Consultant.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review, review of facility's policy and procedure, resident and staff interviews, the facility failed to implement processes to prevent the misappropriation of residents' medications for 4 (Residents #8, #1, #10, and #22) of 4 residents reviewed. The findings included: Review of the facility's policy titled, Abuse Prevention Program revised December 2016 revealed, Our residents have the right to be free from . misappropriation of resident property . Review of the facility's policy titled, Controlled Substances revised December 2012 revealed, Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. On 6/5/25 at 3:23 p.m., an interview was held with the Director of Nursing (DON) to discuss processes in place to prevent neglect and misappropriation of residents' properties. The DON said on 5/10/25 controlled medications pertaining to Resident #8 went missing from the medication cart. The DON stated, I followed what I was told to do for the missing narcotics. I reported it to the Administrator, the police, and the pharmacy. The DON said she did not report the missing controlled medications to the appropriate State agency. She said, Per my Regional Consultant, we reimbursed the resident at our cost and the resident was not harmed. We did not need to notify the State Agency of the misappropriation of a resident's property. Review of the clinical record revealed Resident #8 had a physician's order dated 4/28/25 for Hydrocodone/Acetaminophen 10-325 milligrams (mg), one tablet by mouth every 4 hours for pain. Review of the controlled drug disposition log revealed on 5/9/25 at 8:00 p.m., there were 15 tablets of Hydrocodone/Acetaminophen 10-325 mg remaining. Observation of the Hydrocodone/Acetaminophen pharmacy package with the DON revealed 14 tablets of Hydrocodone/Acetaminophen 10-325 mg remaining, leaving one tablet of Hydrocodone/Acetaminophen 10-325 mg unaccounted for. Photographic evidence obtained. On 6/5/25 at 4:00 p.m., an interview was held with the Administrator to discuss the investigation for the unaccounted tablet of Hydrocodone/Acetaminophen and the reporting the unaccounted controlled substance to the proper authorities. The Administrator said he cordially disagrees and did not have to investigate or report the unaccounted controlled substance as a drug diversion since the facility reimbursed and covered the cost of the medication. He said the incident was not a misappropriation of resident property since they paid to replace the medication. On 6/9/25 at 1:46 p.m., in an interview the DON said on 5/10/25 a total of 4 residents (Residents #8, #1, #10 and #22) had controlled medications unaccounted for. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident #10 had a physician's order for Oxycodone/Tylenol 10/325 mg, 1 tablet every 6 hours as needed for pain. Observation of the pharmacy package with the DON revealed 15 tablets of Oxycodone/Acetaminophen 10-325 mg remaining. The corresponding declining inventory log showed on 5/9/25, 16 tablets remained, leaving one tablet of Oxycodone/Acetaminophen 10-325 mg unaccounted for. Photographic evidence obtained. Review of the clinical record for Resident #22 revealed a physician's order for Oxycodone 5 mg, 1 tablet every 6 hours as needed for pain. Observation of the pharmacy package with the DON revealed 21 tablets of Oxycodone 5 mg remaining. The corresponding declining inventory log showed on 5/9/25, 23 tablets of Oxycodone 5 mg remained, leaving two tablets of Oxycodone 5 mg unaccounted for. Photographic evidence obtained. Review of the clinical record for Resident #1 revealed a physician's order for Chlordiazepoxide 10 mg capsule, one capsule by mouth twice a day. Observation of the pharmacy package with the DON revealed 4 capsules of Chlordiazepoxide 10 mg remaining. The corresponding declining inventory log showed 6 capsules remaining, leaving 2 capsules of Chlordiazepoxide unaccounted for. Photographic evidence obtained. On 6/5/25 at 3:22 p.m., in an interview the DON said on 5/10/25 she discovered controlled medications were missing from the medication cart that Registered Nurse (RN) Staff C was assigned. The DON said it was reported to her that RN Staff C left the facility property several times during her shift with the keys to the medication cart. The DON said RN Staff C was gone for 30 to 40 minutes each time, and did not clock out each time she left as per facility policy. The DON said no one reported RN Staff C's behaviors or the missing medications until the morning. The DON said once she was informed of the missing medications and RN Staff C's behavior, she reviewed the security camera footage and confirmed Staff C had left the facility grounds several times. The DON said, I knew (RN Staff C) was a smoker so I figured she was just leaving to smoke. The oncoming staff reported to her that RN Staff C refused to count the controlled medications, just threw the medication keys on the cart and left the facility. The oncoming nurse counted the controlled substances in the cart and discovered medications were missing and the count sheets were incorrect. The DON said it was discovered on 5/10/25. She said she tried to reach RN Staff C but she did not answer or return the calls. She reported the incident to the local police department; the Florida Board of Nursing and obtained witness statements from staff. The DON said, I did not do an investigation into the missing medications. I was told by the Regional Nurse Consultant that as long as the facility replaced the missing medications, I did not have to report it to the State Agency or complete an investigation. The witness statements are all I have. The DON said RN Staff C no longer worked at the facility, she ran out that night after throwing her keys on the medication cart and just left. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 11:12 a.m., in an interview Resident #1 said she was informed by the facility that someone had taken some of her medication in May. She said, I can't remember the name of it. It did not make me feel good. It was scary thinking that my things are not safe. I never heard back from the facility. They said they would investigate it but did not tell me the outcome. On 6/11/25 at 12:30 p.m., in an interview the Regional Nurse Consultant said he was under the impression they would only have to notify the Board of Nursing and the DEA (Drug Enforcement Agency) since the facility replaced the missing narcotics (controlled medications). He said, I understand now it was misappropriation of resident property, and it should have been reported. I have let all the facilities know. In my mind since we replaced the narcotics, we did not need to report it.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policy and procedure, and staff interviews the facility failed to protect 1 (Resident #900) of 3 residents reviewed from avoidable falls and fall related serious injuries by failing to ensure an effective system was in place to consistently document, report and follow up on residents' falls. Resident #900 was admitted to the facility on [DATE] with a history of falls resulting in hospitalization. Resident #900's cognition was severely impaired. On 4/17/25 at 7:30 p.m., Resident #900 was found on the floor in his room. The facility failed to evaluate Resident #900 after the fall, failed to document the fall in the clinical record, and failed to notify the physician and Director of Nursing for post-fall assessment. There was no evidence of a fall investigation. No root cause analysis was done and no corrective actions were implemented to prevent further incidents of falls. The facility failure to document incidents and ensure appropriate post-fall assessment and care resulted in the delay of identifying a left femur fracture for Resident #900 which could result in severe pain, severe bone infection, delayed healing, and deformity. This failure created a likelihood of serious harm, serious injury or death of Resident #900 and other residents from complication of unidentified injuries and resulted in the determination of Immediate Jeopardy. The findings included: Cross reference F600, F726 and F835. Review of the facility policy titled, Falls- Clinical Protocol revised 3/18 revealed, The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. If the cause of a fall is unclear . a physician will review the situation and help further identify causes and contributing factors . The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or it is not correctable. Review of the facility's policy and procedure titled, Change in a Resident's Condition or Status revised May 2017 revealed, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): accident or incident involving the resident. the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Review of the clinical record revealed Resident #900 was admitted to the facility on [DATE]. Diagnoses included but were not limited to vascular dementia, muscle weakness and the need for assistance with personal care. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the fall risk evaluation dated 4/14/25 revealed Resident #900 scored 10 on the fall risk evaluation. The form noted A score of 10 or higher indicates risk for falls. The evaluation noted the resident did not walk and had a history of 1 to 2 falls in the last 90 days. The evaluation of the resident's balance while standing, was not able to be attempted without physical help. Resident #900 had 1 to 2 predisposing diagnoses and was taking 1 to 2 medication classes that are known to increase fall risk. Review of the baseline care plan dated 4/14/25 revealed the initial goals for the resident included to remain free from fall related injury. The interventions included to provide therapy as ordered, provide hands on assistance of 2 with pivot transfers, and provide hands on assist with walking. Staff was to use the sit to stand lift with 2 staff for transfers. Review of the admission Minimum Data Set (MDS) assessment with a target date of 4/18/25 revealed the resident's cognition was severely impaired. The resident was rarely/never understood and was not able to answer interview questions. Resident #900 had functional limitation in range of motion to both lower extremities. The resident required substantial/maximal assistance to safely move from lying on the back to sitting on the side of the bed. Transfers and ambulation were not attempted due to medical condition or safety concerns. On 4/17/25 at 8:00 p.m., a Fall Risk Evaluation documented a fall risk score of 14 for Resident #900. The evaluation noted the most recent fall was on 4/17/25. The clinical record lacked documentation of the fall and physician's notification. There was no post fall assessment documented and no individualized interventions added to the resident's care plan on 4/17/25 to prevent further falls. On 4/18/5 at 7:11 a.m., Licensed Practical Nurse (LPN) Staff A documented on 4/17/25 at 8:00 p.m., she completed an initial neurological evaluation for Resident #900. The Neurological Evaluation form specified to complete the form for any unwitnessed fall or other accident/injury with possible head trauma. LPN Staff A documented the evaluation of the lower extremities strength noted, Right leg is strong and Left leg is strong. Review of the physician's orders revealed on 4/18/25 at 2:14 p.m., Unit Manager Registered Nurse (RN) Staff B wrote an order for 2 view xray [sic] of the right hip and knee one time only. Review of Treatment Administration Record (TAR) for April 2025 revealed RN Staff C placed her initials on the TAR on 4/18/25 at 9:46 p.m., with a check mark verifying the X-ray of the right hip was done. Complete review of the clinical record failed to reveal documentation of results for the right hip X-ray for Resident #900. There was no documentation the therapy department was notified of the resident's fall. Review of the Physical Therapy treatment encounter notes revealed on 4/18/25 at 2:23 p.m., the Physical Therapy Assistant (PTA) documented Resident #900 verbalized right knee pain with all mobility tasks and also pointing to groin/hip area verbalizing pain. The PTA documented a note was left in the Attending Physician's folder and the Director of Rehab was notified. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documentation in the clinical record the Director of Rehab notified the nursing staff of Resident #900's complaint of pain to the right knee, right groin and hip area. Review of the Occupational Therapy progress notes revealed on 4/23/25 Resident #900 had declined in functional mobility tasks requiring maximum assistance and transfer to the wheelchair with maximum assistance of 2. Review of the physician's orders dated 4/14/25 revealed to administer 2 tablets of Acetaminophen tablet, 325 milligrams by mouth every 4 hours as needed for general discomfort. Review of the Medication Administration Record (MAR) for April 2025 revealed on 4/18/25, the resident's pain level was 1 (mild pain). A pain level of 0 was entered for all other day and evening shifts. There was no documentation on the MAR Resident #900 received the ordered Acetaminophen on 4/18/25. On 4/24/25 at 12:00 a.m., a hospital transfer form noted Resident #900 was emergently transferred to the hospital. The reason for the transfer was, Altered mental status. On 6/5/25 at 10:30 a.m., in an interview related to Resident #900's fall, the Director of Nursing (DON) denied knowledge of the fall and stated, The resident never had a fall at the facility. She said the resident was sent to the local emergency room (ER) for altered mental status on 4/23/25. She said she was not aware the fall risk evaluation completed on 4/17/25 noted Resident #900 sustained a fall on 4/17/25 and was not aware of the right hip and knee X-ray order dated 4/18/25 for Resident #900. On 6/5/25 at 11:00 a.m., in an interview, Unit Manager RN Staff B denied knowledge of Resident #900's fall. She verified on 4/18/25 she entered the order in Resident #900's electronic clinical record for a 2 view X-ray of the right hip and knee. She said, I don't know why I entered the physician's order for the X-ray. When asked about the results of the X-ray, RN Staff B said the X-ray was never done. RN Staff B said there was no formal logbook or system in place to track diagnostic orders like X-rays to ensure they were done. She said the process after a resident's fall was to notify the DON, the physician and the family. She confirmed the lack of documentation the physician, and the DON were notified of Resident #900's fall. She said, From what I can see, that wasn't done. On 6/5/25 at 3:33 p.m., in an interview the DON said there was a breakdown in protocol. She said, There was a breakdown in following the facility procedures after a resident fall. Staff should know how to do the incident report. On 6/6/25 at 8:44 a.m., in a telephone interview Licensed Practical Nurse (LPN) Staff A confirmed on 4/17/25 Resident #900 was found on the floor in his room. She said the resident was attempting to toilet himself. LPN Staff A said the resident fell due to weakness. She notified the DON and the Physician but verified the lack of documentation in the clinical record that the DON and physician were notified of the fall. LPN Staff A said she could not recall if she contacted the resident's family. LPN Staff A said after the fall she did not put any interventions in place to prevent future falls and she did not document the fall on the 24-hour shift report to ensure the next shift provided follow-up care. She said she did not obtain the order for the right knee and hip X-ray. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/6/25 at 1:45 p.m., an interview was held with the DON to discuss systems and processes in place to identify residents at risk for falls and ensure individualized interventions were in place to minimize the risk of avoidable falls and fall related injuries. A list of residents at risk for falls was requested during the interview. The DON said the facility had no program or system in place to identify residents who were at risk for falls. The DON could not provide a list of residents at risk for falls. She provided an incident by incident type report from 1/5/25 through 6/5/25. The report listed 15 falls for April 2025. Resident #900's fall was not included in the report. Review of the hospital record revealed Resident #900 was admitted on [DATE]. The hospital course noted the resident was sent to the emergency room (ER) from the nursing facility for abnormal labs and altered mental status. The resident was recently admitted to the hospital on [DATE], through April 14, 2025, after having a non-syncopal fall. The resident was discharged to a nursing facility. According to the resident's spouse, Resident #900 was doing well and walking while he was there. He had a fall on the 2nd day at the nursing facility and has not been ambulatory since then and has not been acting his normal self. A CT (computerized tomography) scan of the abdomen and pelvis dated 4/24/25 at 3:45 p.m., noted an acute appearing L4 (4th lumbar vertebrae) anterior superior endplate fracture. A CT of the right lower extremity dated 4/24/25 at 3:55 p.m., revealed a comminuted (bone broken in multiple fragments) intertrochanteric right femoral fracture. Adjacent fluid and hematoma (collection of clotted blood) with stranding (indication of bleeding and inflammation in the injured area). On 6/6/25 at 3:14 p.m., in an interview Resident #900's Attending Physician and Medical Director said, I would love to tell you yes, that I was notified of [Resident #900]'s fall but I was not. If I could bring something to you, I would have it in my hands to give to you. The Attending physician said, I was notified yesterday of the incident. I tried to track down the order for the X-ray of the right hip but I do not know who gave that order. It could have been an on-call physician. The staff put everything in my name. The Attending Physician said the process is to notify his Advanced Practice Registered Nurse (APRN). If the APRN does not return the call in an hour, it will come to him. If it is urgent, they notify him or his partner. When an order is given, the process to ensure follow-up depends. Normal, non-urgent things will come that day or the next day so they can see the patient. The physician or the APRN are to follow up on adverse events. The physician said, I do not know what happened with this process with this patient. The physician said he reviewed Resident #900's entire file and went over the case with the APRN. He said, I don't have an answer as to why I was not notified of the fall and why it was not documented. We found nothing. He said, I do not remember getting a call about Resident #900 having pain. They had nothing documented. On 6/11/25 the immediate actions implemented by the facility and verified by the survey team included: On 6/11/25 the survey team verified through record review and interview with the DON and Administrator that the licensed nurse who failed to properly assess and complete accurate incident report has been suspended. On 6/11/25 the survey team verified through review of the education log and staff interviews that licensed nursing staff were educated to document all incident findings in the new incident reporting platform (5/27/25). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/11/25 the DON and Administrator explained and demonstrated the use of the new reporting system, including how the information is reviewed and tracked. On 6/11/25 the survey team verified through record review that on 6/7/25 the Regional Nurse educated the Unit Manager who entered the X-ray order but did not follow up on her job description, following up on physician's orders, and daily tasks assigned, and consistent training of staff on her unit. Unit Manager Staff B verified she received training regarding her job description, follow up on physician orders and training her staff. On 6/11/15 the survey team verified through record review and interview with the DON and Administrator that the facility had an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting on 6/6/25. There was documentation the facility reviewed the system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, including the Medical Director. The survey team reviewed Ad Hoc QAPI minutes for verification to prevent system failures. Verified daily meetings to include a 24-hour report. Daily 24-hour reports for 6/7/25 through 6/11/25 were reviewed to verify resident issues were being captured and reviewed. On 6/11/25 the survey team verified through review of the education and staff interviews that the Regional Nurse educated the Administrator, the DON, the Assistant Director of Nursing (ADON), Unit Manager, MDS (Minimum Data Set) nurses, Social Services, Wound Care Nurse, HR (Human Resources) Director, Maintenance Director, Therapy Director, Activities, Business Office Manager, Staffing Coordinator, CDM (Certified Dietary Manager), Admissions Coordinator, and Housekeeping Supervisor on fall prevention. The facility has implemented a train-the-trainer format. On 6/11/25 the survey team verified through review of the education and therapy staff interview that the therapy staff was educated on reporting changes in condition and falls to the Director of Rehab or designee who will then report findings to the DON/designee via email immediately. The Rehab Director verified the process was for his staff to notify him of any resident changes. The Rehab Director will email DON immediately. On 6/11/25 the survey team verified through review of evaluations, and audits and interview with the DON that evaluations, including fall risk evaluation, and changes in condition were documented in the electronic medical recordkeeping system, and audited daily. On 6/11/25 the survey team verified the Regional Nurse Consultant, the DON, ADON and wound nurse educated the licensed nursing staff and conducted competencies on regulation F689 related to falls and incidents. The survey team verified that as of 6/8/25, 34 of 36 licensed nursing staff, 21 of 21 managers and 136 of 145 general staff completed the required training. The survey team verified through staff interview that any staff who has not completed the training will not be scheduled to work or allowed to work until they complete the required training.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility's policy and procedures and staff interviews the facility failed ensure nursing staff had the appropriate skills set, competencies and oversight to provide safe nursing care and meet the needs of 1(Resident #900) of 3 residents reviewed for falls. Resident #900 was admitted to the facility on [DATE] after a fall resulting in hospitalization. Resident #900's cognitive skills for daily decision making were severely impaired. The resident was rarely understood. On 4/17/25 Resident #900 was found on the floor in his room. The nursing staff failed to document the fall, failed to notify the physician and failed to report the fall to the next shift and therapy department to ensure appropriate follow up assessment and interventions to prevent further falls. The nursing staff failed to document accurately in the clinical record and failed to ensure that physician ordered diagnostic X-rays were obtained. The failure to ensure nursing staff were competent and had the necessary skills sets to provide safe nursing care resulted in the delay of identification of a left femur fracture for Resident #900 which could result in severe pain, severe bone infection, delayed healing, and deformity. This failure and the failure to provide ongoing nursing oversight created a likelihood of serious harm, serious injury or death of Resident #900 and other residents from complication of unidentified injuries and resulted in the determination of Immediate Jeopardy. The findings included: Review of the facility policy titled, Falls- Clinical Protocol revised March 2018 revealed, The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, any observations of the events, etc. For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall. Often, multiple factors contribute to a falling problem. If the cause of a fall is unclear . a physician will review the situation and help further identify causes and contributing factors . The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or it is not correctable. Review of the facility's policy and procedure titled, Change in a Resident's Condition or Status revised May 2017 revealed, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): accident or incident involving the resident. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . Review of the clinical record revealed Resident #900 was admitted to the facility on [DATE]. Diagnoses included but were not limited to vascular dementia, muscle weakness and the need for assistance with personal care. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment with a target date of 4/18/25 revealed Resident #900's cognitive skills for daily decision making were severely impaired. Resident #900 required substantial to maximal assistance with activities of daily living, including toileting and bed mobility. The MDS noted Resident #900 was rarely/never understood. Review of the baseline care plan dated 4/14/25 revealed Resident #900 the initial goals for the resident included to remain free from fall related injury. The interventions included to provide therapy as ordered, hands on assistance of 2 with pivot transfers, provide hands on assist with walking, and use the sit to stand lift with 2 staff for transfers. Review of the fall risk evaluation dated 4/14/25 revealed Resident #900 was at risk for falls. The resident had a history of 1 to 2 falls in the last 90 days. The evaluation of the resident's balance while standing, was not able to be attempted without physical help. Resident #900's risk factors for falls included 1 to 2 diagnoses and 1 to 2 medications classes that are known to increase fall risk. A Fall Risk Evaluation dated 4/17/25 at 8:00 p.m., documented Resident #900's most recent fall was on 4/17/25. Complete review of Resident #900's clinical record failed to reveal documentation the nursing staff evaluated and documented the resident's fall, including when and where the fall happened, whether the fall was witnessed or unwitnessed. There was no documentation the nursing staff identified and added pertinent individualized interventions to prevent subsequent falls to address clinically significant consequences of falling. Review of the physician's orders revealed on 4/18/25 at 2:14 p.m., Unit Manager Registered Nurse (RN) Staff B wrote an order in Resident #900's clinical record for 2 view xray [sic] of the right hip and knee one time only. Review of Treatment Administration Record (TAR) for April 2025 revealed RN Staff C placed her initials on the TAR on 4/18/25 at 9:46 p.m., with a check mark verifying the X-ray of the right hip was done. Complete review of the clinical record failed to reveal documentation of results for the right hip X-ray for Resident #900. On 6/5/25 at 11:00 a.m., in an interview, Unit Manager RN Staff B verified on 4/18/25 she entered the order in Resident #900's electronic clinical record for a 2 view X-ray of the right hip and knee. She denied knowledge of Resident #900's fall on 4/17/25 and said, I don't know why I entered the physician's order for the X-ray. When asked about the results of the X-ray, RN Staff B said the X-ray was never done. She verified RN Staff C placed her initials on the TAR on 4/18/25 at 9:46 p.m., with a check mark verifying the X-ray of the resident's right hip and knee were done. When asked about the process to ensure physician's ordered diagnostic testing were completed and ensure the results are communicated to the ordering practitioner, RN Staff B said there was no formal logbook or system in place to track diagnostic orders like X-rays to ensure they were done. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When asked about the process to ensure timely physician notification of residents' incidents, including falls, Unit Manager RN Staff B said the process included to notify the physician, the Director of Nursing (DON) and the resident's family of the fall. After reviewing the clinical record, RN Staff B verified the lack of documentation the physician and the DON were notified of Resident #900's fall on 4/17/25 as per the facility's process. She said, From what I can see, that wasn't done. Review of the Physical Therapy treatment encounter notes revealed on 4/18/25 at 2:23 p.m., the Physical Therapy Assistant (PTA) documented Resident #900 verbalized right knee pain with all mobility tasks and also pointing to groin/hip area verbalizing pain. The PTA documented a note was left in the Attending Physician's folder and the Director of Rehab was notified. The clinical record lacked documentation that the therapy department was notified of Resident #900's fall on 4/17/25. Review of the Occupational Therapy progress notes revealed on 4/23/25 Resident #900 had declined in functional mobility tasks requiring maximum assistance and transfer to the wheelchair with maximum assistance of 2. Further review of the Physical Therapy Treatment Encounter Note dated 4/24/25 revealed, Reason for missed session: Sick, Pt (Patient) unable to be seen this date. Nursing is addressing excessive urinary bleeding episode. Tx (treatment) held this date per DON request. The clinical record lacked documentation of nursing progress notes related to the urinary bleeding. On 6/5/25 at 10:30 a.m., in an interview related to Resident #900's fall on 4/17/25, the Director of Nursing (DON) denied knowledge of the fall. She stated, The resident never had a fall at the facility. She said the resident was sent to the local emergency room (ER) for altered mental status on 4/23/25. The DON said she was not aware the fall risk evaluation completed on 4/17/25 noted Resident #900 sustained a fall on 4/17/25. She said she was not aware of the order dated 4/18/25 for a right hip and knee X-ray for Resident #900 and did not know why the X-ray was not done. On 4/24/25 at 12:00 a.m., a hospital transfer form noted Resident #900 was emergently transferred to the hospital. The reason for the transfer was, Altered mental status. Review of the hospital record revealed Resident #900 was admitted on [DATE]. The hospital course noted the resident was sent to the emergency room (ER) from the nursing facility for abnormal labs and altered mental status. The resident was recently admitted to the hospital on [DATE], through April 14, 2025, after having a non-syncopal fall. The resident was discharged to a nursing facility. According to the resident's spouse, Resident #900 was doing well and walking while he was there. He had a fall on the 2nd day at the nursing facility and has not been ambulatory since then and has not been acting his normal self. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A CT (computerized tomography) scan of the abdomen and pelvis dated 4/24/25 at 3:45 p.m., noted an acute appearing L4 (4th lumbar vertebrae) anterior superior endplate fracture. A CT of the right lower extremity dated 4/24/25 at 3:55 p.m., revealed a comminuted (bone broken in multiple fragments) intertrochanteric right femoral fracture. Adjacent fluid and hematoma (collection of clotted blood) with stranding (indication of bleeding and inflammation in the injured area). The hospital note documented, The staff did place a Foley catheter and noticed that the patient had hematuria (blood in the urine) which is a new finding for him. The clinical record lacked documentation of a physician's order to insert a urinary catheter. On 6/5/25 at 3:33 p.m., an interview was held with the DON to discuss Resident #900's fall and fracture diagnosed at the hospital on 4/24/25. The DON said, There was a breakdown in following the facility procedures after a resident fall. Staff should know how to do the incident report. On 6/6/25 at 8:44 a.m., in a telephone interview Licensed Practical Nurse (LPN) Staff A confirmed on 4/17/25 Resident #900 was found on the floor in his room. She said he was attempting to toilet himself and fell due to weakness. She said she notified the DON and the Physician and verified the lack of documentation that the physician and DON were notified of the resident's fall on 4/17/25. LPN Staff A verified after the fall, she did not put any interventions in place to prevent further incidents of falls for Resident #900. LPN Staff A also verified she did not document the fall on the 24-hour shift report to alert the oncoming shift of the resident's fall and ensure post-fall follow up care. On 6/6/25 at 1:45 p.m., an interview was held with the DON to discuss facility's systems and processes in place to identify residents at risk for falls. The DON said she could not provide a list of residents who were at risk for falls. She said the facility had no program or system in place to identify residents who were at risk for falls. She provided an incident by incident type report from 1/5/25 through 6/5/25. The report listed 15 falls for April 2025. Resident #900's fall was not included in the report. On 6/6/25 at 3:14 p.m., in an interview, the Medical Director and Resident #900's attending physician said, I would love to tell you yes, that I was notified of [Resident #900]'s fall but I was not. If I could bring something to you, I would have it in my hands to give to you. The Attending physician said, I was notified yesterday of the incident. I tried to track down the order for the X-ray of the right hip but I do not know who gave that order. It could have been an on-call physician. The staff put everything in my name. The Attending physician said the process is to notify his Advanced Practice Registered Nurse (APRN). If the APRN does not return the call in an hour, it will come to him. If it is urgent, they notify him or his partner. When an order is given, the process to ensure follow-up depends. Normal, non-urgent things will come that day or the next day so they can see the patient. The physician or the APRN are to follow up on adverse events. The physician said, I do not know what happened with this process with this patient. The physician said he reviewed Resident #900's entire file and went over the case with the APRN. He said, I don't have an answer as to why I was not notified of the fall and why it was not documented. We found nothing. He said, I do not remember getting a call about Resident #900 having pain. They had nothing documented. The Medical Director said he thought the APRN gave the order to insert the urinary catheter but he could not find an order for the catheter. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Place Healthcare and Rehabilitation Center	2370 Harbor Blvd Port Charlotte, FL 33952

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/6/25 at 4:12 p.m., an interview was held with the DON to discuss nursing oversight to ensure nursing staff had the appropriate competencies and skills set to provide safe nursing and related services. The DON said the management team is present and participates in stand up meetings. They go over risk every day and handle any concern right there. The Administrator goes around to each person and see if there is anything going on. They review incidents, falls and that kind of things. The incident reporting system notifies them of falls. Sometimes a progress note is put in and it comes up on the 24-hour report. When she goes into the risk system, she reviews the progress notes and if anything is missing, she calls the nurse back in. They follow up with falls for 72 hours, therefore there should be documentation. The DON said since the nurse did not write a note about Resident #900's fall, it did not show up on the 24-hour report to alert her of the fall. She said the evaluations, such as neurological evaluations do not trigger on the 24-hour report. The DON said she identified a break in the system. They have never followed up and reviewed the listing report for lab and X-rays orders to ensure they were done. The DON said she did not like the nurses taking verbal orders. She said, I am going to educate the nurses not to take verbal orders. She said she would prefer if the practitioners put their own order into the system, they have remote access to the system. Nursing would confirm the orders. The DON said staff knew about Resident #900's fall and change in condition, they knew about it and they did not report or chart it. 2 Certified Nursing Assistants were in the room with the nurse after the fall, they knew. Documentation is only a small part of it. She said the facility currently did not have a nursing supervisor for the evening shift (3:00 p.m. to 11:00 p.m.) or the night shift (11:00 p.m. to 7:00 a.m.) and the nurses were in charge at night. The DON said ultimately staff needed to be trained that they were not here to collect a paycheck. They needed to report anything, big or small. She said she did not have access to therapy notes as they used a different system and if therapy does not report it, I don't know about it. She said therapy documented in their notes about Resident #900's complaint of pain and not participating in therapy but did not bring it up at morning meeting. On 6/11/25 the immediate actions implemented by the facility and verified by the survey team included: On 6/11/25 the survey team verified through record review and interview with the DON and Administrator that the licensed nurse who failed to properly assess and complete accurate incident report has been suspended. On 6/11/25 the survey team verified through record review that on 6/7/25 the Regional Nurse educated the Unit Manager who entered the X-ray order but did not follow up on her job description, following up on physician's orders, and daily tasks assigned, and consistent training of staff on her unit. Unit Manager Staff B verified she received training regarding her job description, follow up on physician orders and training her staff. On 6/11/25 the survey team verified through review of the education and staff interviews that on 6/8/25 the licensed nursing staff were educated on performing a complete and accurate evaluation and on completing a complete and accurate incident report. Licensed nursing staff was also educated to immediately notify the attending physician, the nursing supervisor on duty, and the DON of any resident incident. (continued on next page)

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/11/25 the survey team verified through record review and interview with the DON that the DON or designee review the 24-hour report on a daily basis to identify any change in condition, orders, or any outstanding follow-up that is required. On 6/11/25 the survey team verified through review of the daily order listing report and interview with the DON. The DON or designee reviews the daily order listing report to ensure follow up on any orders within the last 24 hours. On 6/11/25 the survey team verified through review of the education log and staff interviews that licensed nursing staff were educated to document all incident findings in the new incident reporting platform that went into effect on 5/27/25. On 6/11/25 the DON and Administrator explained and demonstrated the use of the new reporting system, including how the information is reviewed and tracked. On 6/11/15 the survey team verified through record review and interview with the DON and Administrator that the facility had an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting on 6/6/25. There was documentation the facility reviewed the system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, including the Medical Director. The survey team reviewed Ad Hoc QAPI minutes for verification to prevent system failures. Verified daily meetings to include a 24-hour report. Daily 24-hour reports for 6/7/25 through 6/11/25 were reviewed to verify resident issues were being captured and reviewed.

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews and review of facility policy and procedure the facility administration failed to utilize its resources effectively to prevent the neglect of 1 (Resident #900) of 3 sampled residents and maintain oversight to ensure nursing staff competency to deliver safe nursing care and related services. Resident #900 was admitted to the facility on [DATE]. Resident #900's cognition was severely impaired. Resident #900 was dependent on staff for activities of daily living. On 4/17/25 Resident #900 was found on the floor in his room. The fall was not documented in the clinical record. There was no post fall assessment or physician notification. The facility administration was not aware of the resident's fall and did not identify the nursing staff's failure to document the fall, the failure to notify the physician and the failure to assess the resident after the fall. The facility administration processes did not include monitoring systems to ensure all residents incidents are identified, documented and immediately reported for appropriate follow up. On 4/24/25 Resident #900 was emergently transferred to the hospital and diagnosed with a right femoral fracture. The facility's administration failure to prevent neglect and the failure to provide ongoing nursing oversight created a likelihood of serious harm, serious injury or death of Resident #900 and other residents from complication of unidentified injuries and resulted in the determination of Immediate Jeopardy. The findings included: Cross reference F600, F689, F726. Review of the Administrator's job description, signed and dated 1/28/25 revealed the primary purpose of the position is, to direct the day-to-day functions of the facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times. Ensure that all employees . follow the Facility's established policies and procedures . (continued on next page)

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Director of Nursing Services job description signed and dated 6/17/24 revealed the primary purpose of the position is, to plan, organize, develop, and direct the overall operation of our Nursing Service Department in accordance with current federal, state and local standards, guidelines, and regulations that govern our Facility and as may be directed by the Administrator to ensure that the highest degree of quality care is maintained at all times. Administrative functions . Plan, develop, organize, implement, evaluate, and direct the nursing service department, as well as its programs and activities, in accordance with current rules, regulations, and guidelines that govern the nursing care facilities . Develop methods of coordination of nursing services with other resident services to ensure the continuity of the residents' total regime of care. Develop, implement, and maintain an ongoing quality assurance program for the nursing service department. Review of the clinical record for Resident #900 revealed an admission date of 4/14/25. The Nursing admission Evaluation and Fall Risk Evaluation dated 4/14/25 revealed Resident #900 was at risk for falls due to a history of 1 to 2 falls in the last 90 days,1 to 2 predisposing diagnoses and was taking 1 to 2 medication classes that were known to increase fall risk. On 4/17/25 a Fall Risk Evaluation documented Resident #900 sustained a fall on 4/17/25. Complete review of Resident #900's clinical record failed to reveal documentation the nursing staff evaluated and documented the resident's fall, including when and where the fall happened, whether the fall was witnessed or unwitnessed. There was no documentation the nursing staff identified and added pertinent individualized interventions to prevent subsequent falls to address clinically significant consequences of falling. Review of the physician's orders revealed on 4/18/25 at 2:14 p.m., Unit Manager Registered Nurse (RN) Staff B wrote an order in Resident #900's clinical record for 2 view xray [sic] of the right hip and knee one time only. Review of Treatment Administration Record (TAR) for April 2025 revealed RN Staff C placed her initials on the TAR on 4/18/25 at 9:46 p.m., with a check mark verifying the X-ray of the right hip was done. Complete review of the clinical record failed to reveal documentation of results for the right hip and knee X-rays. On 4/24/25 at 12:00 a.m., a hospital transfer form noted Resident #900 was emergently transferred to the hospital. The reason for the transfer was, Altered mental status. Review of the hospital record revealed Resident #900 was admitted on [DATE]. The hospital course noted the resident was sent to the emergency room (ER) from the nursing facility for abnormal labs and altered mental status. The resident was recently admitted to the hospital on [DATE], through April 14, 2025, after having a non-syncopal fall. The resident was discharged to a nursing facility. According to the resident's spouse, Resident #900 was doing well and walking while he was there. He had a fall on the 2nd day at the nursing facility and has not been ambulatory since then and has not been acting his normal self. (continued on next page)

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A CT (computerized tomography) scan of the abdomen and pelvis dated 4/24/25 at 3:45 p.m., noted an acute appearing L4 (4th lumbar vertebrae) anterior superior endplate fracture. A CT of the right lower extremity dated 4/24/25 at 3:55 p.m., revealed a comminuted (bone broken in multiple fragments) intertrochanteric right femoral fracture. Adjacent fluid and hematoma (collection of clotted blood) with stranding (indication of bleeding and inflammation in the injured area). On 6/5/25 at 10:30 a.m., in an interview the Director of Nursing (DON) denied knowledge of Resident #900's fall. She said, The resident never had a fall at the facility. On 6/5/25 at 11:00 a.m., in an interview, Unit Manager RN Staff B verified on 4/18/25 she entered the order in Resident #900's electronic clinical record for a 2 view X-ray of the right hip and knee. She denied knowledge of Resident #900's fall on 4/17/25 and said, I don't know why I entered the physician's order for the X-ray. When asked about the results of the X-ray, RN Staff B said the X-ray was never done. She verified RN Staff C placed her initials on the TAR on 4/18/25 at 9:46 p.m., with a check mark verifying the X-ray of the resident's right hip and knee were done. When asked about the process to ensure physician's ordered diagnostic testing were completed and ensure the results are communicated to the ordering practitioner, RN Staff B said there was no formal logbook or system in place to track diagnostic orders like X-rays to ensure they were done. When asked about the process to ensure timely physician notification of residents' incidents, including falls, Unit Manager RN Staff B said the process included to notify the physician, the Director of Nursing (DON) and the resident's family of the fall. After reviewing the clinical record, RN Staff B verified the lack of documentation the physician and the DON were notified of Resident #900's fall on 4/17/25 as per the facility's process. She said, From what I can see, that wasn't done. Review of Unit Manager RN Staff B's job description signed and dated 9/30/24 revealed the primary purpose of the job position is to assist the Director of Nursing Services in planning, organizing, developing, and directing the day-to-day functions of the Nursing Service Department . to ensure that the highest degree of quality care is maintained at all times. The duties and responsibilities included to, Ensure that all nursing services personnel are following their respective job descriptions . Ensure that direct nursing care be provided by a licensed nurse . qualified to perform the procedure . Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care . On 6/5/25 an attempt was made to conduct a telephone interview with RN Staff C who was no longer employed at the facility. Both telephone numbers listed in the personnel files were disconnected. On 6/6/25 at 8:44 a.m., in a telephone interview Licensed Practical Nurse (LPN) Staff A confirmed on 4/17/25 Resident #900 was found on the floor in his room. She said he was attempting to toilet himself and fell due to weakness. She said she notified the DON and the Physician and verified the lack of documentation that the physician and DON were notified of the resident's fall on 4/17/25. LPN Staff A verified after the fall, she did not put any interventions in place to prevent further incidents of falls for Resident #900. LPN Staff A also verified she did not document the fall on the 24-hour shift report to alert the oncoming shift of the resident's fall and ensure post-fall follow up care. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Physical Therapy treatment encounter notes revealed on 4/18/25 at 2:23 p.m., the Physical Therapy Assistant (PTA) documented Resident #900 verbalized right knee pain with all mobility tasks and also pointing to groin/hip area verbalizing pain. The PTA documented a note was left in the Attending Physician's folder and the Director of Rehab was notified. A review of the physician binder at the nurse's station failed to reveal documentation of the resident's complaint of pain on 4/18/25. The binder was empty. Review of the Occupational Therapy progress notes revealed on 4/23/25 Resident #900 had declined in functional mobility tasks requiring maximum assistance and transfer to the wheelchair with maximum assistance of 2. There was no documentation the nursing department was notified of the resident's complaint of right knee, right groin/hip area pain on 4/18/25. On 6/6/25 at 3:14 p.m., in an interview Resident #900's attending physician and Medical Director said he was not notified of Resident #900's fall until 6/5/25. The physician said the process was for the nursing staff to notify the Advanced Practice Registered Nurse (APRN) of any resident's incident. If the APRN does not return the call in an hour, it will come to him. It it's urgent, they notify him or his partner. The physician said he reviewed Resident #900's entire file and went over the case with the APRN and did not have an answer as to why he was not notified and why the incident was not documented. He said, We found nothing. The physician said he tried to track down the order for the right hip X-ray but did not know who gave that order. On 6/6/25 at 4:12 p.m., an interview was held with the DON to discuss the neglect of Resident #900 and oversight to ensure nursing staff had the appropriate competencies and skills set to provide safe nursing and related services. The DON said during stand up meetings in the morning all the management team is present. The management team goes over risk concerns and handle concerns right then and there. They review falls, risk and that kind of things. The incident reporting system notifies them of falls. A progress note is sometimes put in and it comes up on the 24 hour report. If the nurse does not write a note about an incident, the concern does not populate in the 24 hour report. The evaluations, including fall evaluations do not trigger on the 24 hour report. When she goes into the risk system she reviews the progress notes and if anything is missed they call the nurse back in. They follow up with falls for 72 hours so there should be documentation. The DON said, I found a break in our process. There has never been a review of orders put in. I would not know if a nurse took an order and did not put it in the system. I do not like nurses putting verbal orders in the system. I feel like it is a strong system if the physician or Nurse Practitioner put the orders in and we confirm. The DON said currently they did not have a 3-11 shift or an 11-7 shift supervisor. She said, The nurses are in charge of the building at night. I would have to speak with the Administrator about how to notify the nurses of who is in charge. Right now, we do not have anything. On 6/9/25 at 9:50 a.m., an interview was held with the Administrator to discuss the day-to-day oversight to assure the highest degree of quality care is provided to the residents at all time and ensuring staff follow established policies and procedures. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator discussed the process for Quality Assurance and Performance Improvement (QAPI) and went over the QAPI meeting minutes for the last meeting on 5/23/25 included a review of falls for April 2025. The Administrator said he was not aware of the resident's fall. The Administrator said he reviewed Resident #900's entire clinical record with the DON and the Regional Nurse Consultant and could not find any pertinent information related to Resident #900's fall on 4/17/25, or the reason for the indwelling catheter insertion. The facility provided documentation of an annual in-service calendar and an orientation schedule to ensure new employees are trained in facility's policies and processes before providing care to the residents. The training included residents rights , abuse, neglect and exploitation training. The annual in-service calendar for 2025 included: January 2025: Accident awareness. February 2025: Abuse and Neglect. March 2025: Residents Rights. April 2025: Risk Factor for Falls. On 6/11/25 the immediate interventions implemented by the facility and verified by the survey team included: On 6/11/25 the survey team verified through record review and interview with the DON and Administrator that the licensed nurse who failed to properly assess and complete accurate incident report has been suspended. On 6/11/25 the survey team verified through record review that on 6/7/25 the Regional Nurse educated the Unit Manager who entered the X-ray order but did not follow up on her job description, following up on physician's orders, and daily tasks assigned, and consistent training of staff on her unit. Unit Manager Staff B verified she received training regarding her job description, follow up on physician orders and training her staff. The Unit Manager re-signed her job description. On 6/11/25 the survey team verified 6/7/25 the Regional Nurse consultant reviewed the Administrator and the DON's job description with them to ensure oversight and effective monitoring are maintained to ensure the competency of staff to provide safe nursing care and related services to [NAME] the needs of residents and prevent the neglect of other residents. On 6/11/25 the survey team verified through review of the education and interview with the DON and Administrator that on 6/7/25 the Regional Nurse educated the Administrator and DON on abuse, neglect, falls, changes in conditions, physician notification and documentation. On 6/11/25 the survey team verified through review of the daily order listing reports and the daily 24-hour reports, and interview with the DON and Administrator that as part of maintaining oversight, the DON or designee reviewed the reports on a daily basis. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6/11/25 the survey team verified through interview with the DON and the Regional Nurse that the DON or designee is on call 24 hours a day, 7 days a week for all staff contact regarding administrative or nursing issues. On 6/11/15 the survey team verified through record review and interview with the DON and Administrator that the facility had an ad hoc (unplanned) QAPI (Quality Assurance and Performance Improvement) meeting on 6/6/25. There was documentation the facility reviewed the system failures and processes that needed to be implemented to prevent these failures in the future. The plan was approved by all in attendance, including the Medical Director. The survey team reviewed Ad Hoc QAPI minutes for verification to prevent system failures. Verified daily meetings to include a 24-hour report. Daily 24-hour reports for 6/7/25 through 6/11/25 were reviewed to verify resident issues were being captured and reviewed. On 6/11/25 the survey team verified through review of in-services and interviews with the Administrator and the DON that on 6/7/25, the Regional Nurse educated the administration staff to document all findings in the new incident reporting system. The DON and Administrator verified they do a final review of the incidents and sign off that they reviewed the incident reports. On 6/11/25 the survey team verified through review of the education and interview with the Regional Nurse, the DON and Administrator that 21 of 21 administration staff were educated. This included the DON, Administrator, Assistant Director of Nursing, Unit Manager, Minimum Data Set (MDS) nurses, Social Services, Wound care nurse, Human Resources Director, Maintenance Director, Therapy Director, Activities Director, Business office Manager, Staffing Coordinator, Certified Dietary Manager, and Admissions were educated.